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THE CANADIAN HOSPITAL

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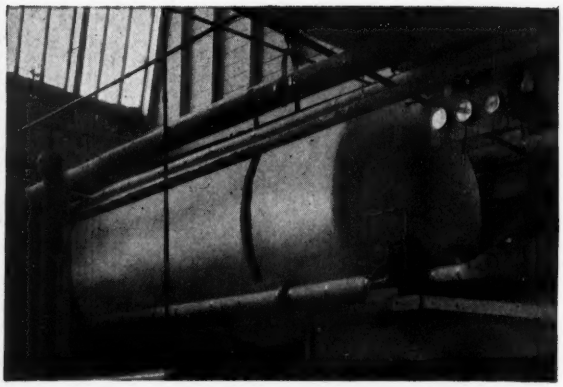

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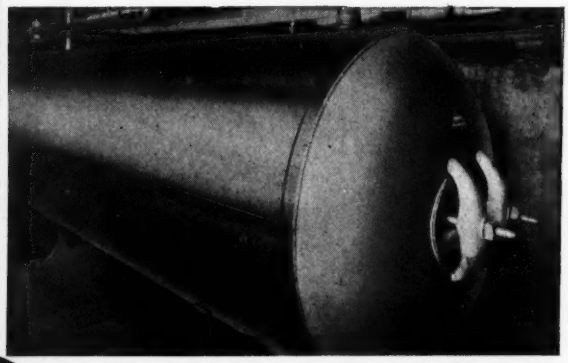

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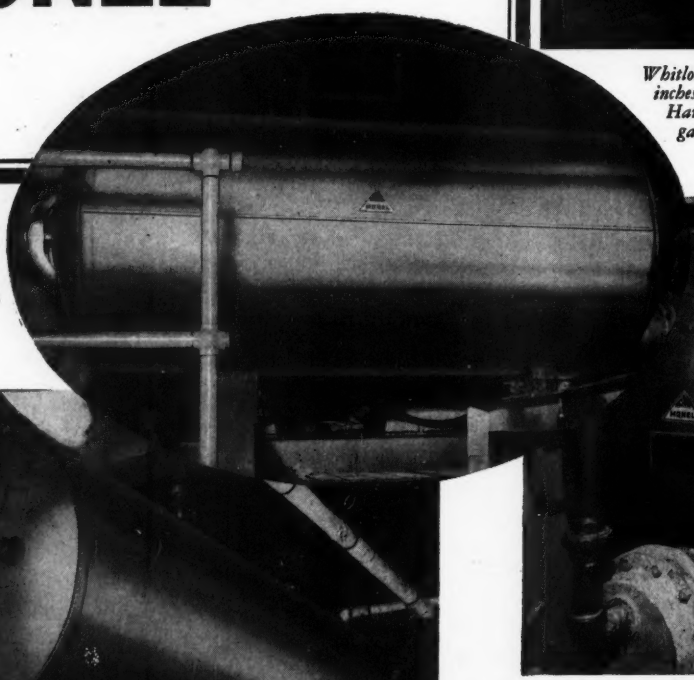

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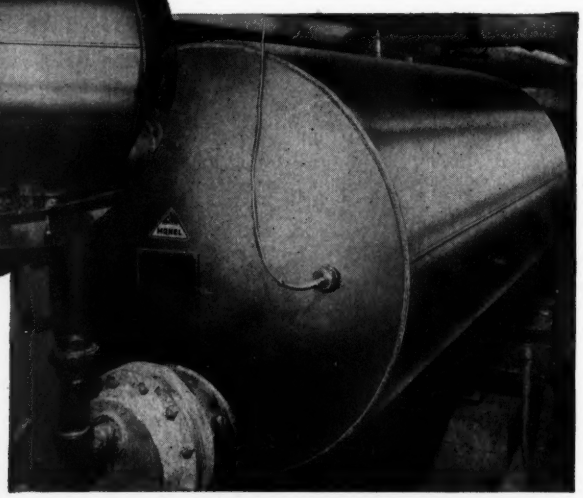

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"The Canadian Hospital"

Official Journal of the

Canadian Hospital Council

Vol. 18 JUNE, 1941 No. 6

CONTENTS

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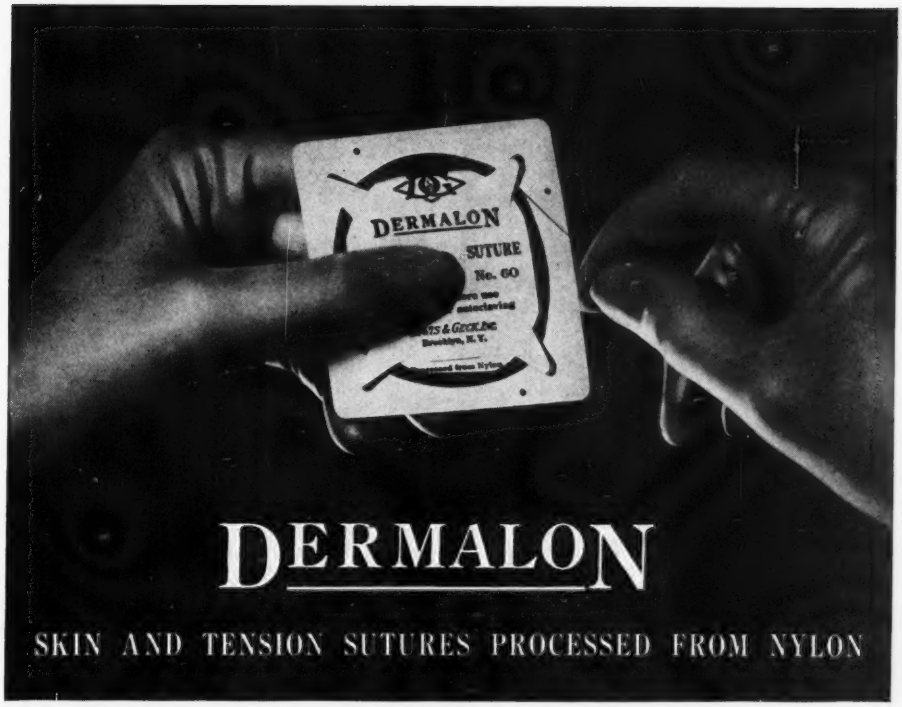
Authorized by the Post Office Department as Second Class Matter. The Canadian Hospital is published monthly by The Canadian Hospital Publishing Co., 57 Bloor St., West, Toronto, Ontario.



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ADVANCES IN CANNING TECHNOLOGY

I. Requirements for the Modern Canning Factory

● During the first decade of the 19th Century, Nicholas Appert, an obscure French confectioner, worked out empirically the basic principles of canning. In 1811, the first English edition of his book on the "Art of Preserving" was published (1). This text lays down the fundamentals of the canning process; it describes the necessary organization of a canning establishment and its equipment; and it lists canning procedures for more than 50 foods of both animal and plant origin.

Viewed in the light of modern knowledge, Appert's book is surprisingly complete and many of his observations amazingly accurate. Naturally, in the 130 years since his book was published, many advances have been made in canning technology. Consequently, when Appert's quaintly worded descriptions of the requirements for the use of his process are compared with those of modern commercial practice, some insight may be had as to the vast improvements which have been wrought in this important field of food preservation since its humble beginning.

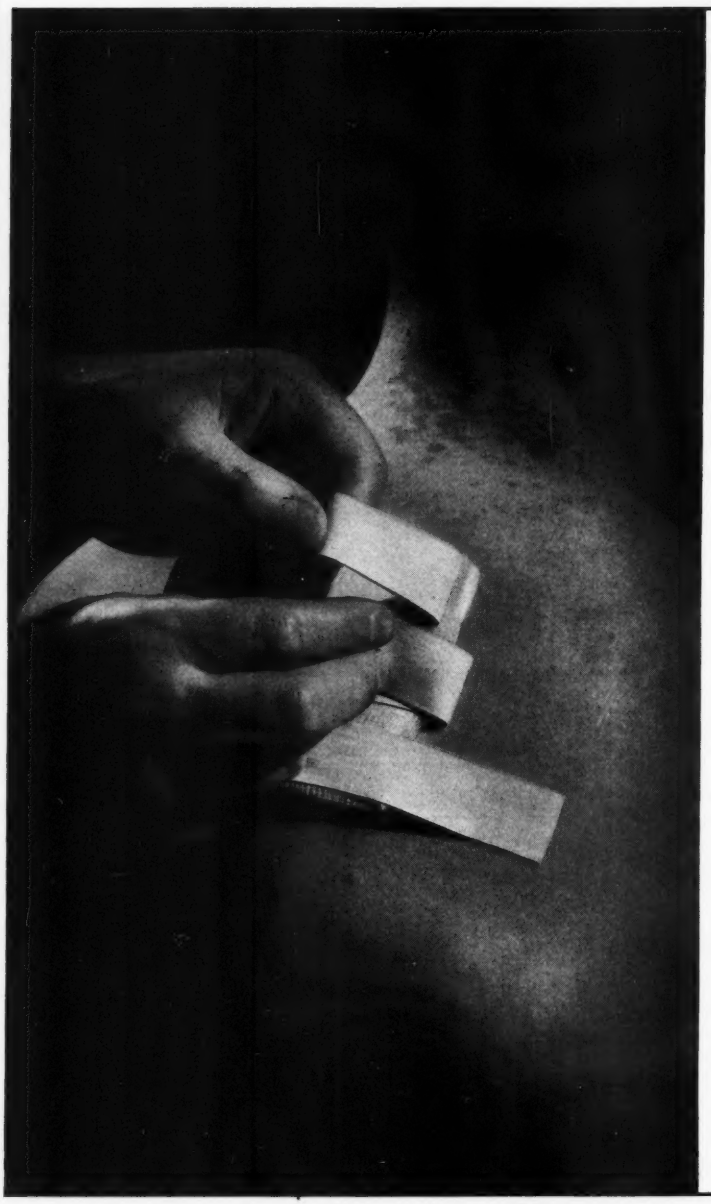
One striking contrast between the old and new in canning lies in Appert's description of the necessary features of a canning establishment of his day. Appert's establishment apparently was composed of seven rooms or "apartments". Four of these were equipped to handle the preparation of fruits, vegetables, and foods of animal origin; the fifth room was devoted to the cleaning and storage of the glass bottles used as containers; the sixth room was the "sealing" room in which the bottles were corked after filling with food; the last room contained the large covered kettle in which the sealed containers were processed in boiling water.

The requirements for the modern cannery are, of course, much more exacting, both from the standpoint of factory site, arrangement, and equipment. Today, canneries must be located close to the fields, orchards, or waters from which the raw materials are harvested. Rapid handling of freshly harvested raw stock—a prime requisite for quality of the final product—is thus facilitated. The factory site must also be chosen so that an adequate supply of potable water is available. The modern canning plant is arranged specifically for handling the product or products that will be canned. This provides for continuous, rapid, and even flow through the various operations comprising the canning procedure for the particular product.

Needless to state, the equipment requirements of the modern canning factory are also much more complex than in the days of Appert. Present-day, large-volume production—necessary for the manufacture of a low-cost product—requires the use of high-speed automatic equipment for conveying the raw materials through the cleansing, preparatory, and all other operations of the commercial canning procedure. Frequently, much of this equipment must be constructed of special metals or alloys; in all cases it must be so constructed as to permit rapid, thorough, periodic cleansing. To maintain and control this highly specialized machinery, a skilled mechanical staff is necessary.

Space will not permit fuller description of other requirements for the cannery of today. Thousands of such factories combine to form the canning industry, whose products already have become so essential in our modern civilization and in our national defense. Commercially canned foods have fulfilled every prediction of Appert by whose "extensive practice and long perseverance" a new means of food preservation was made possible.

(1). The Art of Preserving All Kinds of Animal and Vegetable Substances, M. Appert, Black, Parry, and Kingsbury, London, 1811.



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Harvey Agnew, M.D., *Editor*

The CANADIAN HOSPITAL

Toronto, June, 1941 **Vol. 18** **No. 6**

Changes Along the Hospital Food Front

War-Time Feeding a Challenge to Food Administrators

FLORENCE W. STACEY, B.Sc., M.A.
Dietetics Editor,
The Canadian Hospital

THE hospital dietitian to-day faces the challenge of a changing food scene which moves with quickened pace. No longer can she administer an efficient, economical, scientific food service along routine lines or by time-worn rules.

Food for health, for strength, for life, has become a matter of universal significance. The feeding of large groups of people has taken on a new and purposeful meaning. Food in the hospital, whether military or civilian, whether for patients or personnel, in these days assumes a timely importance.

The need for food adequacy has never before reached such momentous proportions in the scheme of things. To guard and maintain this level of adequacy must be the responsibility of the dietitian in hospital. At the same time she must cultivate a cheerful alertness, a keen judgement, a preparedness for changes which come with war-time feeding. She must be ready and able to manipulate, to adjust, to substitute.

What are some of these changes which have appeared along the Food Front? To quote the Dominion Bureau of Statistics: "The Bureau's index number of wholesale prices for foods and beverages has advanced from 79.6 in January, 1940, to 83.4 in March, 1941, indicating an increase of 4.8%."

The practical food administrator realizes that an economy of operation requires of her a careful analysis of local existing food cost changes, which in turn may mean food substitutions while still maintaining adequacy and satisfaction for the patient.

We in Canada have, as yet, been confronted with only voluntary rationing. Institutional co-operativeness is a first essential in national food preparedness. If the use of bacon, shall we say, must be curtailed for reasons of national importance, the food director must serve it less frequently and must find a substitute, such as eggs, for the menu. When the market no longer offers fruit juices from distant lands, the dietitian must "boost" Canadian applejuice. Cakes and pastries formerly prepared with all butter, suffer no real quality and flavour loss when a part is substituted by lard—and there is still sufficient butter used daily by the individual to cover the vitamin requirement.

The dietitian must use all the ingenuity and enthusiasm at her command to concoct new and interesting dishes which may become the substitutes of to-morrow. Hers too, becomes a problem of education—teaching large groups to adjust, to change, of necessity, some food habits of years.

In war-time, the problem of changing personnel consistently looms up in the hospital food field. Here, too, the dietitian must hold herself ready to skilfully select and quickly and effectively train those who fill the ranks.

The hospital dietitian in these times must serve her institution wisely and well, if she too would serve her country— her slogan, "Make Canada Strong by Making Canadians Stronger".

Canadian Nutrition Problems

E. W. McHENRY, M.A., Ph.D.,
School of Hygiene, University of Toronto

NUTRITION is now recognized as part of a sound public health programme. Not only can definite diseases be caused by faulty nutrition but it is also clear that subsistence on inadequate supplies of food lowers vitality, reduces resistance to infection, and impairs working efficiency. The growth and health of children can not be normal unless they are properly fed, nor can healthy babies be produced if mothers suffer from malnutrition.

Intensive scientific research during the past thirty years has contributed great increases in nutritional knowledge. It is now possible to define with some accuracy the composition of a diet which is optimal for health. This knowledge can be assembled in a dietary standard which expresses the quantities of all the various food constituents which must be supplied. A dietary standard applicable to Canadian conditions has been arranged by the Canadian Council on Nutrition; this sets forth requirements for calories, protein, fat, minerals and vitamins needed to furnish adequate diets. Such a standard becomes practicable when its scientific terms are translated into common foods. When this is done for the Canadian standard it is evident that the people of this country can secure an optimal diet from Canadian food sources. This is important at the present time and recognition of this fact would do much to improve markets for Canadian farm products.

Many Diets Still Inadequate

While it is true that Canadian food resources are sufficient, or could be made so, to provide all of our citizens with proper food supplies, evidence is accumulating to indicate that many Canadians are not well fed. Accurate information regarding our nutritional conditions has only been available in recent years. In 1935 the Dominion Department of Agriculture carried out extensive surveys of the consumption of milk and certain protein foods. The results showed that there was a relation between financial income and the use of milk, meat, and eggs. One third of the children in families having the lowest incomes were not receiving milk to drink.

Nutrition in this country is still far from ideal. Nutritional education on basic principles, on cooking and on buying is badly needed.

Surveys of nutritional conditions in the United States and in Great Britain had revealed an amazing amount of under-nutrition. Sir John Orr stated that about two-fifths of the population of Great Britain were poorly nourished. It was known that conditions in some sections of the United States were even worse; in the southern states pellagra, a dietary deficiency disease, was an acute public health problem. Canadian nutritionists suspected that conditions here might resemble those shown to exist in analogous countries like Great Britain and the United States. It was clear that Canadian dietary habits were sufficiently good to prevent the occurrence of severe deficiency conditions; pellagra appeared to be virtually non-existent in Canada and other deficiency diseases were rarely reported. There was, however, a dearth of information regarding actual conditions.

Surveys Confirm Deficiencies

In 1937 Professor Andrew Stewart of the University of Alberta made a study of food purchases in two groups of Alberta families; the results indicated that food supplies might not be entirely adequate. In the same year a Toronto committee carried out a survey of food consumption in one hundred low-income families. This Toronto survey was concerned with the food used by individuals; most previous surveys in other countries had studied the family as a unit. Because of the individual nature of the Toronto survey it was possible to compare different persons in the same household. Fathers were found to be the best fed, young children next, then the older children and the mothers were most poorly supplied with food. It is readily possible to understand why this should be the case. Limited supplies of food were available and the mothers, with characteristic unselfishness, deprived themselves in order that the rest of the family, particularly the bread-winner, should be better off. The question should be raised as to whether the unequal division of food is wise, even if done from the best motives. For the welfare of the country, mothers should be as well fed as the fathers.

This Toronto survey showed that the food supplies were not satisfactory. In many cases there was not sufficient food available to furnish needed calories or satisfactory amounts of most food constituents. Several essential dietary factors were noticeably deficient. Children need calcium for healthy growth of bones; the children in these families received, on the average, about one half the amount of calcium which would be considered adequate. Milk is the chief source of calcium and the data regarding the consumption of milk show why the supplies of calcium were so low. Children need at least a pint of milk per day; the average amount available for these children was half a pint per day. Iron was another constituent which was deficient, particularly in the case of women. Dr. Kennedy of Montreal reported two years ago that 43 per cent of a large group of women examined by him in that city showed evidence of iron-deficiency anaemia. The results of the To-

ronto survey provide the explanation of this high incidence.

Four Illuminating Surveys

Early in 1938, the Dominion Department of Pensions and National Health, recognizing the importance of nutrition in public health activities, organized a Canadian Council on Nutrition. This body, under the leadership of Dr. Wodehouse, was composed of persons interested in nutrition and representatives of a number of societies and groups. The Council saw the need for studies which would provide information regarding Canadian dietary deficiencies and planned four surveys in as many Canadian cities. Three of these, in Halifax, Quebec, and Edmonton, were concerned with families having annual incomes below $1,500, and were comparable to the Toronto survey previously described. A fourth survey in Toronto, covered families with incomes between $1,-500 and $2,400. This survey was planned so that results from it could be compared with those of the low-income survey previously done in Toronto. All of these surveys have involved records of food consumption of individuals. The Halifax survey was under the direction of Prof. E. G. Young of Dalhousie University, Dr. Sylvestre of the Quebec Department of Health was responsible for the Quebec study, and the one in Edmonton was directed by Profs. George Hunter and Bradley Pett of the University of Alberta. All these surveys have now been completed and they provide accurate information regarding dietary conditions among low-income families in Canadian cities.

Nutritional conditions in Halifax, Quebec and Edmonton are strikingly similar to those found among similar families in Toronto. The general picture is one of insufficient food and the occurrence of certain deficiencies is clearly evident in each city. Low-income families are not receiving ample amounts of the protective foods which can be relied upon to furnish minerals and vitamins. *Three* marked deficiencies are shown to exist: *calcium,* particularly for the children, the *B vitamins* for all individuals, and *iron* for women and children. In many cases supplies of vitamin C were meagre. The higher income families in Toronto had definitely better supplies of food but, even in these families, there was a deficiency of the B vitamins. One conclusion can be drawn from these surveys: many families in Canada are not receiving supplies of food which are adequate for health, for proper growth of children, and to maintain working efficiency on a high plane. Canada, a land of plenty with ample food resources, has a nutrition problem.

Courtesy of O.M.A. Bulletin.

The Queen visits the 15th Canadian General Hospital with Col. C. A. Rae and Lt.-Col. R. W. I. Urquhart.

Why should malnutrition exist in this country? It is possible to secure an adequate diet from Canadian sources. Food supplies are available, or could be made so to give everyone an optimal diet. There are only two reasons for a failure to secure proper food supplies, *the inability of some families to purchase an optimal diet* and *a lack of nutritional information.* Perhaps nothing can be done about the economic factor and it is likely that this cause of malnutrition is less important in Canada than it appears on the surface. Many of the low income families studied in these surveys could have had better food supplies if the mothers had been trained to buy economically. If the amounts spent for food are examined, it is clear that greater expenditures did not always mean better food supplies. Indeed the family in the second Toronto survey which spent the least for food had a reasonably good diet.

Nutritional Education Needed

Three types of nutritional education are needed. The first is *instruction in the basic principles of nutrition.* That does not mean that everyone has to think about food in terms of calories or protein or vitamins. Scientific terms need not be used and emphasis can be put entirely upon foods. *Instruction in good cooking methods* is necessary because

(*Continued on page* 42)

The Administrator Takes Stock of the Dietary Department

A. K. HAYWOOD, M.D.,
General Superintendent,
Vancouver General Hospital

THERE is no place in the hospital where the change in duties and responsibilities of a departmental head has been so marked as it has been in the case of the dietitian. Within the last twenty years she has developed into supervisor of the entire food service. One can remember when the dietitian's main and, at times, only duty was to ensure that the instructions of the physician were carried out. Now the department of dietetics ranks next in importance to the training school and nursing profession. Most complaints arise from poor food service.

This department is responsible for the expenditure of from one-quarter to one-third of the hospital budget. At present the trend of operation of the food service is upward—standards of an adequate diet are higher, wages are increasing, and efforts to control the price of farm products have also increased food costs. The following are a few examples of *increased cost* of foods:

	Sept. 1939 (outbreak of war)	May, 1941
Beef	8c lb.	14⅕c lb.
Lamb	13	19
Butter	22	30½
Bread	4	5⅝
Tea	32	48
Coffee	16¼	27

Canned fruit and vegetables have gone up in proportion. Kitchen equipment, crockery and linen have all added their quota to the dietitian's problem at budget time.

The Director of Dietetics should have *full authority and responsibility for the entire hospital food service,* including purchasing from the standpoint of quantity and quality, also the preparation and distribution of cooked foods. Is it wise or reasonable to expect the dietitian to prepare tasty, well cooked food and hand over the serving of her product to inexperienced waitresses or ward maids?

In preparing food for patients the task of the dietitian is not an easy one. In point of age she has to care for patients from the extreme of prematurity to senility. In point of social condition, from the poorest to those in the best of financial circumstances. The appetites vary from the voracious appetite of the healthy labourer, who is suffering from a fracture, to the patient whose appetite is non-existent. In addition to the regular diets she has in many cases to be responsible for the special therapeutic diets for specific diseases.

The dietitian also has to furnish food to doctors whose period of service may be only a year. When one considers that simply eating in the same place for a considerable period of time may have a bad effect on the appetite, it is easy to see how difficult it is to keep these individuals not only satisfied but pleased.

In addition to her administrative duties the Director of Dietetics must be responsible for the teaching of dietetics and dietotherapy, general and practical, to the student nurse.

A glance at the shelves of the modern hospital pharmacy will bear out the importance of the dietitian in the treatment of disease. Some of our old professors of pharmacology would turn over in their graves if they knew how diets have taken the place of long prescriptions. There is not space in a paper of this sort to go into the therapy of diets in the treatment of disease, but some of the outstanding and recognized diets are most beneficial, if not imperative, in the following diseases—rickets, pellagra, scurvy, beriberi, asthma, nephritis, cardiac conditions, anaemia, diabetes, gastric and duodenal ulcers, obesity, typhoid, gout, constipation and countless other conditions for which we no longer write complicated prescriptions.

It is only natural that patients will not enjoy some of these diets. One often conjectures what a help it would be to the dietetic staff if the attending doctor would give his diet orders in front of the patient, and in a few words explain to the patient why this or that food is restricted, and thus seek the patient's co-oper-

(*Concluded on page* 46)

Central Tray Service from the Private Kitchen—University Hospital, Edmonton, Alberta.

Can Good Food be Served in Hospitals?

By HAZEL McINTYRE, M.S.
Lecturer in Foods,
University of Alberta, Edmonton

FOOD in hospitals should be good, certainly. Food served anywhere should be good, whether in public eating places, hospitals or homes. But is it? Consider the food served in public eating places across Canada. Cooking in most homes we think of as good, since our experience generally leads us to this belief, and yet if it is universally good why does the public continue to eat badly prepared and served food away from home? Is it because the belief has been fostered that foods cooked in large quantities cannot be good? There does seem to be a deeply rooted conviction that such foods cannot be as good as home cooked foods under any circumstances, and yet we all have had in restaurants at times, food which was better than any we had ever tasted before and we have found an occasional lunch room where the food was always interesting and good. We cannot dismiss the problem of poor food in institutions as either non-existent or inevitable.

In Canada we have a wealth of raw materials to create fine food and by virtue of a rigorous climate, the appetite to enjoy it. With these as a foundation, we should have established for ourselves a reputation for good food by now, but we are still a long way from this. The reason given by the woman in the home may be lack of training, lack of money or time, or sometimes a frank lack of interest; but in institutions one can place the blame on so many people, each of whom has some responsibility, that the reasons will be as diversified as the number of people concerned. Nevertheless, just as in each home there is someone who sets the standard for food, so there must be in any institution *one person who is determined that food can and will be good.* The greater this determination, the greater will be the achievement.

There is no thought in one's mind that quality in large quantity cookery is an easy thing to achieve, but we all know that it is possible. There are many sources of information on the subject. Years of successful administration have resulted in several excellent books on the management

of food service from the standpoint of equipment, arrangement of units of service, cost accounting, sanitation, personnel management and accurate recipes and methods. Manufacturers of equipment have co-operated with food specialists to produce almost human machines; scientists have been working on the problems of temperatures, proportions and all the changes in cooking which can be controlled by the scientific treatment of foods. They have gone far in solving the problem of "institution flavour". There is nothing obscure about the problem of institution food now.

Good food means the same thing wherever people are being fed. The term does not just mean good, in the sense of being food for one, but it does mean that food should look, smell, feel and taste good. A meal which begins with watery vegetable soup, dry roast beef, lumpy mashed potatoes, unseasoned and partly drained canned peas, and ends with a brown wrinkled baked apple and something incorrectly labeled on the menu as coffee, contains many valuable elements necessary for health, but the food offends every sense which is used in the eating of a meal. The preparation of any food is an exact science; the seasoning and service an art. It is not a bad profession, no matter how hard, that not only gives scope to one's technical skill but brings recurring satisfaction to one's love of beauty.

A meal can renew physical strength and reduce fatigue; it can even change one's outlook on life. A patient can be turned to interest in life again when three times a day he is given a tray of well cooked and attractively served food. The doctor will agree that this contribution to morale is no less important than the actual nourishment. The tray is a break in the quiet routine of the day, and much more of an event than three meals to the healthy person with work to occupy his time and mind. When this anticipation is rewarded by good food, it will lead to appetite and to the taking of sufficient nourishment to sustain life while the body is healing.

One peculiar aspect of hospital food service is the scope of its clientele. No other institution presents such a complex problem. There is not only the problem of serving appetizing food to a large and varied staff and to patients of all ages, but also the problem of serving special diets so that they will be attractive and satisfying. Food has to be taken to most of the people since they cannot come for it. This geographical problem adds considerably to the difficulties involved in keeping texture, flavour and temperature up to the standard. It is a very big job, this one of serving food in hospitals. One appreciates all its difficulties but still one feels justified in demanding perfection of the prospective dietitians in our foods classes, and in warning them that if they aim at less they will have failed themselves and their profession.

Can Civilian Hospital Facilities be Utilized for the Needs of the Defence Force?

Army, Navy, Air and Pensions Officials Discuss Situation with Canadian Hospital Council

ON frequent occasions observance of the large number of hospitals being erected in conjunction with military and other camps or by the Department of Pensions and National Health has promoted the thought: Why, in many instances, could not these facilities be erected in conjunction with civilian hospitals so that, when their use in connection with the war be ended, they could then be utilized for civilian patients for many years to come?

It is accepted that, in many instances, such arrangement would not be possible, for many Army, Air and Navy concentrations are not close to civilian hospital facilities adequate for their needs. But are there not instances where, either the facilities of the local civilian hospitals could be utilized, or, if such be overcrowded now, the money which would be spent by the Federal Government on temporary buildings could be used to erect, or help erect, an annex or wing to the civilian hospital for defence use?

According to the latest figures, the Army now has a large number of hospitals. Most of these range from 15 to 75 beds, but going up to 500 beds. The Air Force has a number of hospitals in Canada and one in Newfoundland. The Naval Service is building a hospital at Esquimalt and one at Halifax. Pensions has 8 hospitals.

The Construction of Hospitals for War Purposes

This matter was given considerable discussion at the March meeting of the Canadian Hospital Council Executive Committee. As a result the following letter was sent to the Prime Minister with copies to the Ministers of National Defence for Army, Air and Naval Services and to the Minister of Pensions and National Health:

"This letter is written at the request of the Executive Committee of the Canadian Hospital Council with the sincere desire of promoting national welfare and economy. During the past year and a half a large number of hospitals, large and small, have been erected or adapted for the care of military patients. We understand that many more have been set up in connection with military camps and areas, the total number aggregating almost one hundred hospitals.

"Obviously it is necessary that extra hospital accommodation be provided for the care of the armed forces and that some of these hospital facilities must be available to the training areas, though this close proximity is now less important with the improvement in roads and ambulance service. Unfortunately a great deal of the construction recently completed or under way is not likely to be of use upon the close of the war and in all probability much of the equipment will be disposed of at considerable loss. It is our studied opinion that in some instances it would be possible to provide this new accommodation in such a way as to ensure its continued utilization for hospital purposes after its need for military patients is ended.

"It is suggested that in communities where competently operated civilian hospitals exist it should be possible to arrange for new construction as a wing or annex to the civilian hospital. In some instances the initial cost might be shared with the Federal Government by the hospital concerned.

At the close of the war, should such accommodation not be needed for the care of the soldiers, it could be turned over to the civilian hospital on a basis to be determined at the time of erection or at the time of the turn-over. In the final analysis the Canadian Government is interested in the welfare of both military and civilian patients and from the viewpoint of national economy the continued use of hospital accommodation and equipment during the reconstruction period and later on is in the best national interest. With the present overcrowding of most civilian hospitals, particularly the lower priced accommodation, and the increasing utilization of hospitals, especially those fully paid services under voluntary hospital insurance plans, such added accommodation would be most acceptable and would ultimately prove of considerable benefit to the people of Canada in the years to come.

"The need for disciplinary control of members of the armed forces while in hospital is fully recognized and this has furnished one logical reason for hesitation in having military and civilian patients under the one control. The difficulty could be overcome by having the new wing or annex entirely under the department concerned, whether it be Department of Defence, Pensions and National Health, Air Force or the Navy. Doctors and nurses from these various services could be utilized in order to maintain this separate control. Food, heating, laundry, could be purchased from the civilian hospital while other commodities such as linen, surgical equipment and drugs, the X-ray or the laboratories, could be either purchased from the hospital or requisitioned from the stores of the appropriate Government department. The net result should be a considerable saving over the cost of the same service if provided separately.

"This suggestion is respectfully submitted with the thought that in areas where such a plan is feasible the arrangement would permit the maximum ultimate use of buildings and equipment and should prove of value in effecting national economy.

Yours very truly,

(Signed) G. F. Stephens, M.D.
President."

Copies of this letter sent to the Presidents and Secretaries of the various hospital associations elicited strong approval.

As a result of this suggestion as to future policy, a conference was held in the office of the Director General of Medical Services on May 8th. This was attended by Brigadier R. M. Gorssline, D.S.O., R.C.A.M.C., Director General of Medical Services, Group Captain R. W. Ryan, Director of Medical Services, R.C.A.F., Surgeon Commander A. McCallum, M.D., V.D., Senior Medical Officer, R.C.N.V.R., Dr. Ross Millar, Director of Medical Services, D.P. and N.H., and by Dr. Geo. F. Stephens and Dr. Harvey Agnew representing the Canadian Hospital Council.

This conference discussed for over two hours the possibilities and limitations of this suggestion. The representatives of the four services, known as the Inter-Departmental Hospital Committee, expressed themselves in full sympathy with the spirit of the request, but reviewed a number of reasons why it has been difficult to put this principle into effect. Briefly these are as follows:

Difficulties

1. *Primary cost of construction.* Huts quite adequate for Defence purposes can be erected for from $800 to $900 a bed. If a wing be erected to conform to civilian hospital construction the cost would be two to four or more times as high. The D.P. and N.H. has built well insulated and substantial huts at as low a figure as $500-$600 per bed.

2. *Speed of construction.* With the speeding up of war preparation and the short notice possible for arranging facilities for the concentrations of Defence Forces, it would frequently be impossible to await the various steps necessary to obtain civilian cooperation, particularly if available Federal funds need to be supplemented by the local civilian authorities.

3. *Distance from a Civilian Hospital.* A number of camps are located at some distance from a civilian hospital. In certain locations cited, the intervening roads are frequently impassable during certain seasons.

4. *Venereal and Isolation Cases.* Civilian hospitals usually do not accept these patients, yet they must be hospitalized.

5. *Hospitals Essential in Permanent Camps.* Where permanent camps have been established, it has been deemed advisable to set up a permanent hospital in connection therewith.

6. *Cost of Operation.* It was the contention of the representatives of both the Army and Pensions that maintenance operations are lower in their hospitals than in most civilian hospitals.

7. *Cannot foretell demand.* Some civilian hospitals are prepared to set aside certain beds for military needs. One difficulty in the way of accepting such reservation has been that, with wide and sudden variations in the size of the camps, such space may prove quite inadequate at times and be idle at other times. No guarantee to fill beds reserved could be made.

It was pointed out, too, that many of these Defence hospitals are not new construction but, as in London, Hamilton, Port Arthur, Portage la Prairie and other places, are rented buildings converted into hospitals.

In some instances the military hospital has been erected immediately beside the civilian hospital. In at least one instance elsewhere in Canada, a proposal to so build was blocked by an exorbitant price being placed by the owner upon the adjacent land.

Many of these hospitals will be in use for many years. In all probability the maintenance of an adequate Defence force will be required for some time. Pensions still had 2,000 patients from the last war in hospital when this war broke out.

Furthermore it was contended that the equipment spent on these hospitals should not be regarded as an economic loss. Should some of these stocks be found superfluous after the war, it is quite likely that the civilian hospitals would benefit. It was recalled that, after the last war, the civilian hospitals were given the first opportunity to buy the surplus government hospital supplies at greatly reduced prices.

The Inter-Departmental Committee agreed to give every consideration to the possibility of using civilian hospitals. Before proceeding with new construction the local situation will be thoroughly studied, each instance being evaluated on its own merits. Brigadier Gorssline emphasized that, to the best of his knowledge, the Army had never built a separate hospital where adequate and satisfactory hospital facilities already existed. It was pointed out, too, that in many of the hospitals, for example, at Port Arthur and at Hamilton, major surgery is not arranged for. In some instances a certain amount of surgery is done.

At the conclusion of the conference, the following statement of general policy was signed by Brigadier Gorssline, Group Captain Ryan, Surgeon Commander McCallum and Dr. Geo. F. Stephens and forwarded as a recommendation to The Honourable the Minister of National Defence:

"The Inter-departmental Hospital Committee, in conjunction with representatives of the Canadian Hospital Council, agree to the general principle of utilizing civilian hospital facilities where conditions warrant, but are of the opinion that each case where additional hospital accommodation is required, should be judged as an entity, taking into due consideration the following factors:

Primary cost of construction
Subsequent cost of operation
Distance from concentration of troops
Speed of construction
Type of cases the Forces have to treat.

"Any representations with respect to a Federal addition requested by a civilian hospital should be made by the local authorities directly to the Federal authorities."

The Biennial Meeting of the Canadian Hospital Council, scheduled for September 10th and 11th, will be held at the Windsor Hotel, Montreal. Reservations are now being received for this important meeting.

WHAT A BABY!

The R. A. F. would seem to have adopted maternity's messenger to carry "babies" with a real kick to the enemy.

(British Official Photograph of a Lockheed Hudson Bomber. Courtesy, O.M.A. Bulletin.)

Present Day Hospital Need Puts Dietitian in the Vanguard

ETHEL C. PIPES, Director of Dietetics, Vancouver General Hospital

THE dietitian has become an administrative officer, for she now has the direction of approximately one-fourth of the total hospital expenditures, plus a very definitely growing educational responsibility. According to McLester (1) "Never was there a time when nutrition so held the centre of the stage. Not only does the lay public realize the importance, but nurses and doctors were never more concerned with dietary adequacy."

Perhaps the clearest picture of the progress of the dietitian's responsibilities is found in the above chart. (2)

The number of dietitians employed did not keep pace with the need, leaving little time for thought of how best to guide this almost mushroom growth. Truly the situation was master of the dietitian, rather than the dietitian master of the situation.

The Dietetic Internship

The principles which have been found to underlie the sound hospital training of graduates in medicine apply with equal force to the internship for dietitians. The final results of such training will depend far less on the physical size and equipment of the institution than on the teaching qualifications of the permanent dietetic staff. The basic course in dietetics is in the basic sciences and their application is on a laboratory basis. No school has yet designed a course in the management of a sulky maid, a temperamental chef, a bull-headed butcher, a slick salesman or a picky patient to say nothing of the intern who feels bacon and eggs are his right each morning, or the nurse whose unrestrained sweet tooth adds curves that she herself dislikes. If the hospital is to have dietitians capable of meeting the every-day practical problems of dietetic management, *it must train them itself.* It is the dietetic internship which solves the problem.

It has been demonstrated that an adequate graduate staff provides the personnel needed for the proper training of the intern. It has been found practical in a number of the progressive hospitals to have a graduate assistant for each seventy-five beds after the first fifty, with a student dietitian for each graduate. If a dietitian is an economically sound investment in larger hospitals, how much more so in those smaller hospitals who are working on slimmer margin. Why not the combined dietitian-housekeeper in the hospital of less than one hundred beds?

A Typical Hospital of the early 1920's One dietitian sufficed for 200-300 beds	**General Organization Department Policies Budgets, Control**	**A Progressive Hospital of the late 1930's** One dietitian needed for each 50 beds	
Nurses	Teaching Out-Patients	*O.P.D. Dietitian*	
Nurses	Visiting In-Patients Teaching In-Patients	*Ward Dietitians or Therapeutic Dietitian*	
Nurses	Formulae Room	*Dietitian on Paediatric Ward*	
Chef or Nurses' Home Matron	Tray Service	*Ward Dietitians or Serving Room Dietitian*	*Chief Dietitian*
Chef or Steward	Dining Room Service	*Administrative Dietitian or Assistant*	
Chef or Steward	Main Kitchen Control Supplies, Equipment	*Administrative Dietitian*	
Dietitian	Teaching Nurses	*Dietitians*	
Dietitian	Special Diets	*Therapeutic Dietitian or Ward Dietitian*	

(*Concluded on page* 44)

"All Out" for the Victory Loan

THE Victory Loan 1941 Campaign is now under way. Preparations have been made for this campaign as never before and necessary it is, too, for the raising of 600 millions in one great effort is a terrific undertaking for a small country like Canada. That means approximately $240 for the average family of four people! And when we think of the many thousands who can contribute nothing like this amount, it means that those more fortunate will need to far exceed this sum.

We are now beginning to realize that this is a war to the death. It is not a war that can be stopped at leisure. This war must go on until either the Nazi machine is destroyed—or we are destroyed. A Nazi victory will mean the enslavement of this nation—probably within the next decade at the latest. Every dollar we have would then be confiscated, along with our last worldly possessions—and ultimately perhaps the very spirit of our people, at least of those still living.

Every dollar that is not needed for the necessities of life should be loaned to the government in this, its greatest crisis. To be swayed now by the bait of a somewhat higher though less secure dividend may be disastrous. Nothing short of our maximum effort can be considered now.

Sales Tax on Building Materials

What effect will the new regulations of the Department of National Revenue have upon the purchase of building materials by the hospitals?

The present budget resolutions still before parliament, but with every indication of being accepted, will provide for the repeal, effective as of April the 30th, 1941, of the formerly existing exemption from sales tax for the items listed in Section 3 of The Special War Revenue Act under the caption "Building Materials". This covered a large number of items, such as brick and tile, lumber, plaster boards, paints, roofing, plumbing, glass, furnaces, hardware, structural steel, etc. All these articles were tax free, whether purchased by the hospital or the contractor. This exemption, irrespective of who purchased the material is now off.

However, the earlier arrangement under The Special War Revenue Act, whereby "Articles and materials for the sole use of any bona fide public hospital certified to be such by the Department of Pensions and National Health, when purchased in good faith for use exclusively by the said hospital and not for resale" will still continue in effect. This means that the former arrangement should be followed to obtain the sales tax exemption: that is to say, it would be necessary for the *hospital, not the contractor, to buy the material.* This should be done under its own name, the contractor telling the hospital authorities what items and what quantities to purchase.

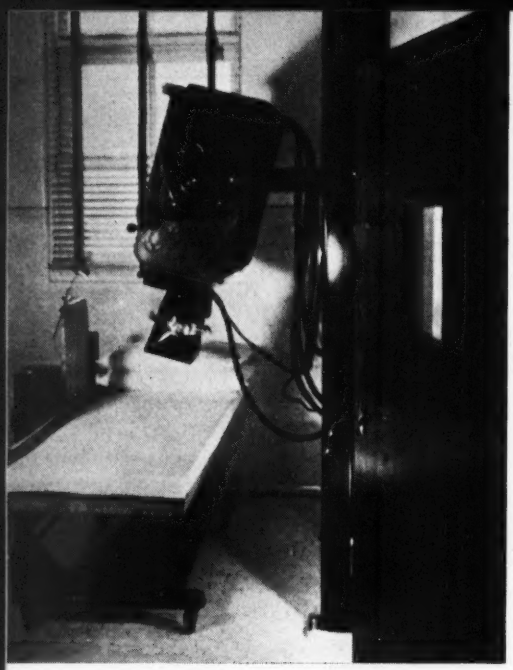
Canadian Dietetic Association to Hold Annual Meeting in Toronto

The Annual Meeting of The Canadian Dietetic Association is to be held on Saturday, June 21st, in the Household Science Building, University of Toronto, Toronto, Ontario.

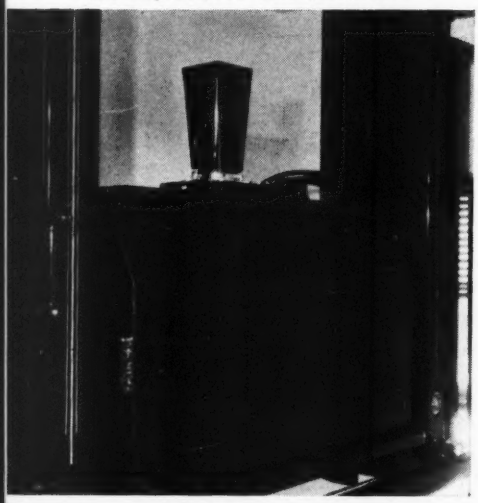
A very full and interesting programme is being planned, and arrangements are being made for an informal luncheon and a dinner with special speakers.

Medical Supplies from Canada Received at Crete

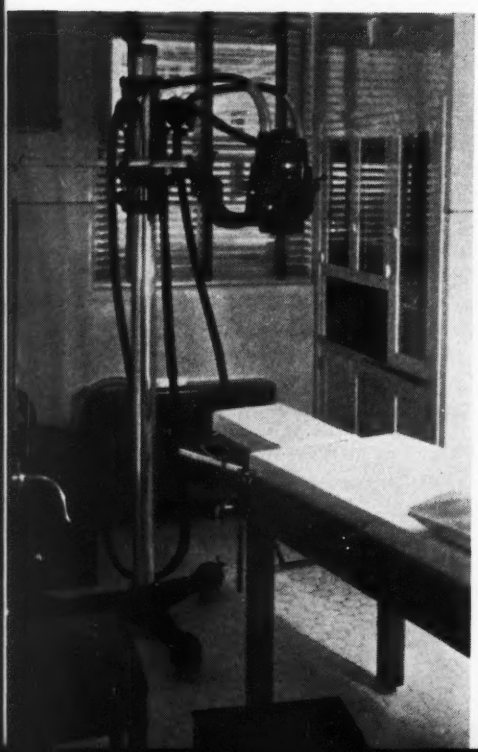
Canadian medical supplies valued at $100,000 reached Crete via Egypt last month. The shipment was the first "instalment" of supplies purchased by Canadian subscriptions in aid of Greek war refugees.



Above, 400,000 *volt machine.*



Above, 220,000 *volt machine.*



Left, 60,000 *to* 100,000 *volt machine.*

Right, Examining rooms for head, neck and chest cases and for abdominal and gynaecological cases.

Fine X-ray Department at St. Boniface Hospital

NEW x-ray equipment installed at a cost of $40,000 in the St. Boniface Hospital. St. Boniface, Manitoba, makes the department one of the most modern in Canada.

The department is under the direction of Dr. Digby Wheeler, Dr. H. M. Edmison and Dr. A. W. McCulloch. Dr. Edmison is at present serving overseas as radiologist with the No. 5 Canadian General Hospital.

The department is located on the top floor of the hospital, which eliminates the expense of insulating the ceilings of the treatment rooms. The walls of these rooms, however, are lead insulated to prevent the penetration of the rays. The equipment consists of three all shock-proof machines with a master control panel and inter-room communication system. There is also a fluoroscope room and two waiting rooms.

The largest machine weighs three and a half tons and has a capacity of 400,000 volts. It is used for deep-seated cancer. A 220,000 volt machine is used to treat both deep cancer and less severe cases. A 60,000 volt machine treats superficial cancer and other skin diseases. It also has an attachment for treatment of the throat.

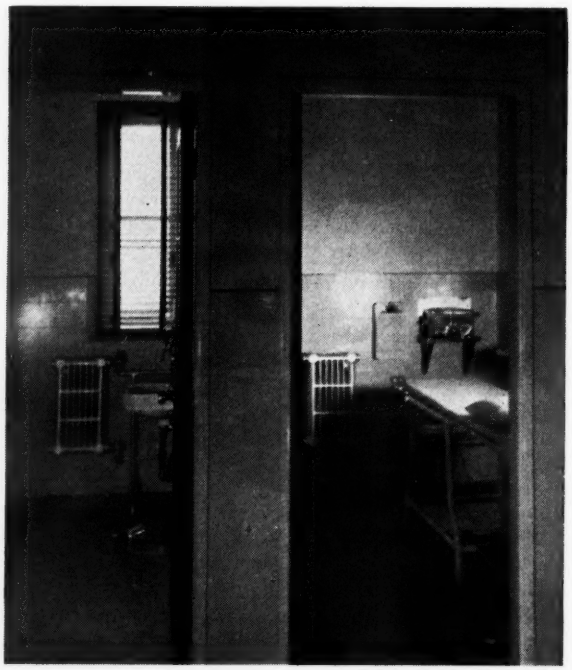
La Lutte contre le Cancer

Au département des Rayons X de l'hôpital de Saint-Boniface, on vient d'installer, au coût de $40,000 trois nouvelles machines modernes destinées au traitement du cancer.

L'Institut de Traitement et de Recherche du Cancer dit que le département thérapeutique de l'hôpital est l'un des plus modernes d'Amérique. Il est sous la direction des Drs Digby Wheeler, H. M. Edmison et A. W. McCulloch. Le Dr Edmison sert actuellement outremer comme radiologiste à l'hôpital général canadien No. 5.

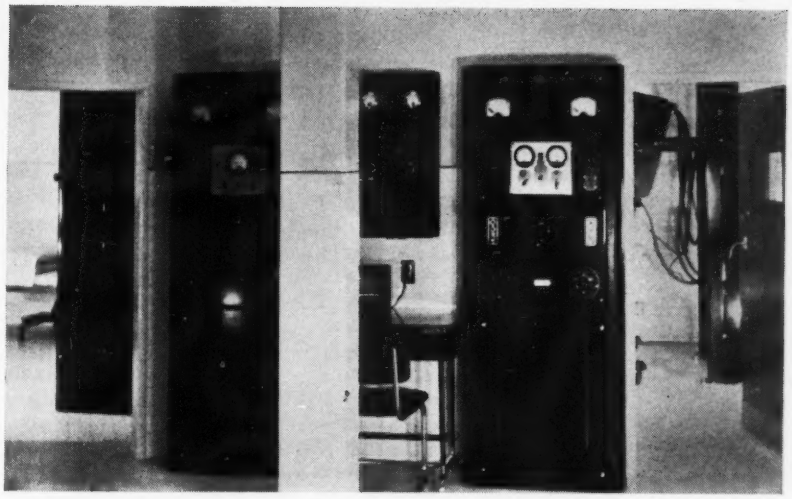
Le nouveau matériel comprend trois machines complètement a l'épreuve des chocs, avec tableau de contrôle central, système de communication entre chambres et deux chambres d'examen. De plus, il y a la chambre au fluorescope.

Le service est situé à l'étage supérieur de l'hôpital, de sorte que tous les rayons pénétrant en haut peuvent s'échapper dans le ciel. Le pouvoir de pénétration de ces rayons est tel que les chambres sont doublées de



plomb incrusté dans les murs.

La plus grande machine, qui pèse trois tonnes et demie a une capacité de 400,000 volts. En dépit de ses dimensions, elle peut être manoeuvrée très facilement. Elle est employée pour le traitment du cancer à racines profondes. La machine de 220,000 volts est employée pour le traitement du cancer invétéré et de maladies moins graves. La machine de 60,000 volts est employée pour le traitement du cancer superficiel et autres maladies de la peau. Pour le traitement de la gorge et des autres parties internes, il y a un tuyau avec un ingénieux système d'éclairage et de miroir à l'intérieur pour repérer la partie malade.



Master control panels.

Output of Doctors to be Increased

Change Implies Eight Months' Internship

To meet the increasing need for more doctors in the army, navy and air force, the medical schools in Canada have agreed to hasten the output of young medical men so that three classes instead of two can be graduated every two years. This decision was reached at a special conference attended by the Deans of the medical schools in Canada and held in the office of the Director General of Medical Service at Ottawa on May the 16th. This can be accomplished by dividing the twenty-four months period into three units of eight months each.

As it is desirable that recent graduates have some internship training before going into one of the armed forces or into civilian work, hospitals are to be requested to develop an internship of eight months in lieu of the present twelve months basis. This would apply to both graduate and undergraduate internships.

The schedules in the medical schools have not been announced as we go to press, except in the case of McGill and Toronto. However, as there was general agreement on the procedure to be followed at the Ottawa conference, it is presumed that the dates adopted for McGill and Toronto will be fairly typical.

The schedule adopted by the University of Toronto on May 22nd is as follows:

Medical classes will resume on August the 25th next. The graduating class will run through to March 27th, 1942, thus permitting the incoming final year to take the Medical Council of Canada examinations and be available for an internship on May the 1st, 1942. The incoming fifth year, starting August the 25th next, will carry through until the end of June, 1942, by which time they will have completed not only their fifth year but the first trimester of the sixth year. Taking a brief holiday then until August the 25th they will resume their studies and will graduate December the 20th, 1942. This will make them available for internship on January the 1st, 1943. The next class graduates the end of August, 1943, and will be available for internships on September 1st, 1943, then May 1st, 1944, etc. The length or brevity of this arrangement will be determined by the length of the war.

McGill men start August 25th. If these schedules be adopted even though only approximately by the other schools, it would mean that the hospitals will be asked to shorten the period for the interns now reporting on July 1st. This will mean a revamping of the schedules for the incoming interns, for such an arrangement seems necessary to meet the urgent demands of the war situation. (See editorial.)

350 Doctors Needed This Year By Defence Forces

"The Defence Forces need 350 more doctors this year and anticipate a requirement of 500 additional doctors in 1942", said Brigadier R. M. Gorssline, Director General of Medical Services, in a recent statement to Canadian Hospital Council representatives. "We shall make every effort not to interfere with the completion of the first year of internship, but otherwise we are ready to accept any eligible and physically fit doctor with a licence to practise in any of our provinces."

As of March 31st of this year, 1422 doctors were serving in the Defence Forces.

Obiter Dicta

Planning for the Future

ALTHOUGH there are few signs yet that the war is drawing to a close, it is by no means too early to be giving serious thought to what is going to happen after the war. Even though the war continue for several years, we must remember that it will take a long time to properly formulate plans and to mould public opinion to support the wisest course of action.

Without doubt we can expect a new order. Winston Churchill has prophesied it and not without a shrewd knowledge of human reactions. We made a long step in that direction after the last war, the extent of which change few of us have really recognized. Soldiers got a liking for what was virtually health insurance and of a non-contributory variety, too. Across the line the "bonus-grab" taught men the political power of united effort. Along came the depression and not only the unemployed but the seasonal worker went on relief. Hospital legislation as we know it has come almost entirely since the last war. State paternalism is growing apace. The income tax and succession duties were devised to pay for this paternalism.

And we can expect more change this time. Unprecedented industrialization in this war, coupled with shrinking markets for normal trade, cannot but spell a tremendous industrial upheaval when it is no longer necessary to grind out guns and planes night and day. Unemployment insurance will soften the blow but there is a limit to even its buffer effect. Our war-time "bootstrap" prosperity may be succeeded by a busy reconstruction era but we cannot count on it. Moreover the great body of ex-service men and women accustomed for a period of years to medical and hospital care without personal obligation will not take kindly to the old pre-war task of dodging hospital and medical bill collectors.

Taxes, already at unprecedented heights, are bound to continue high for years, irrespective of an early or remote ending to the war. We haven't paid for the last war yet, nor for the Boer War, and the billions now being spent will make it idle to expect ever to see in our lifetime a return of the old time tax rates. What effect will these taxes and surtaxes have on philanthropy, so essential to meet a steadily rising cost in providing hospital care? What will be the influence on our thinking of the great stream of Britishers and others whom we may expect to come to Canada after the war, bearing in mind that practically all of them will come from countries following some form of extensive health insurance?

Hospitals are now realizing that the old order is very likely to receive a most serious shaking up in the next few years. Whether hospital care insurance will lead the way to the ultimate solution or be cast aside for a more radical form of care remains to be seen. The fate of the voluntary hospital depends upon the astuteness and vision of its leaders. Anticipating that divers interests in the political field, little if at all concerned with hospital welfare, are likely to have a vital influence upon the future of our hospitals, it is most important that those in the hospital field, and in the allied medical and nursing groups, work out sane and sound policies for the years to come. It is most commendable that the Department of Pensions and National Health should take the initiative this month in calling together representatives of various national organizations interested in health to consider health organization and rehabilitation after the war. The Canadian Hospital Council, too, might well be giving this subject intensive study.

Interns and Military Service

ELSEWHERE in this issue reference is made to the decision at the recent conference of Deans of Medical Schools in Canada to speed up the output of doctors to meet the greatly increased military demands. The recommendation to continue the instruction with but minor let-up so that three classes instead of two can be graduated in each two year period, in other words every eight months, will increase by fifty per cent the number of doctors available for military or civilian service.

This decision will have a fundamental bearing upon hospital internships. In order to provide the graduating doctors with the clinical experience obtained through internship, hospitals will be asked to modify their existing schedules so that internships will be based upon the eight months rotation rather than one of twelve months. By inference it is presumed that longer courses would be on a basis of sixteen months or two years as hitherto, but in the latter case based upon the eight months rather than twelve months unit.

Hospitals accepting interns are now being requested to revamp their schedules to meet this situation. It is anticipated that in most institutions little difficulty will be experienced in so doing, particularly as at the end of each eight months a new group of interns will be available. In some instances, for example, in large hospitals where rather elaborate schedules have been worked out, adjustment will not be so easy, but as this is an emer-

gency measure and it is essential that every effort be made to focus all of our resources upon the winning of the war, it is anticipated that hospitals will make every effort to co-operate in this unusual situation.

Although some interns have been accepted by the different Services before the completion of their internship, and although no statement of policy has been authorized for publication, it is generally understood that the policy of the Services has been to encourage interns to complete their first year of internship before joining the army. Inasmuch as the Director General of Medical Services has expressed approval of this arrangement to give the medical graduates an eight months internship, it would seem probable that this policy of permitting the intern to complete his junior internship before enlistment would be continued. The effect this will have on the many American students who like to serve in Canadian hospitals and who must obtain a credit of twelve months internship before writing the examinations of the National Board of Medical Examiners has not been determined, but correspondence is now under way with that body. It would be hoped that they would receive an eight month's credit at least and perhaps the remaining four months' internship credit could be obtained by military service or other form of training.

Whether or not in the case of graduate internships the allocations will be made as in the past two years by the Canadian Intern Board operating under the aegis of the Canadian Association of Medical Students and Interns with the collaboration of the Canadian Hospital Council and the Canadian Medical Association Department of Hospital Service has not been determined. As developments take place further announcements will be furnished to the hospital field. In the meantime intern committees and hospital administrators are urgently requested to give serious consideration to whatever changes would be necessary to set up the eight months schedule commencing next May 1st, thus limiting the schedule of the incoming interns to ten months rather than twelve.

What the United States is Doing Respecting Interns and Military Service

THE National Headquarters of the Selective Service System in Washington issued on May 2nd a memorandum to all state directors respecting the occupational deferment of doctors, interns and medical students. Taking the viewpoint that the internship is an essential part of medical education, a policy is stated that no intern who gives reasonable promise of becoming an acceptable medical doctor should be called to military service before completing his internship. "Under the present War Department policy, interns who meet army physical standards can be commissioned in the Medical Reserve Corps and, if so commissioned, will not be called to active military duty during the first year of internship. Consequently, even though a local board places an intern in Class 1-A by reason of determining that he can be spared from the community, such intern may, by becoming a member of the Medical Reserve Corps, complete his first year's internship."

Following the same reasoning the National Headquarters has stated in the same memorandum that promising medical students should be permitted to graduate and serve their internship before being called up for military duty. Local boards are reminded that a deferment is not an exemption and that the obligation and liability for military service remains at the expiration of this deferment.

The Strategy of Town Planning

"THE Strategy of Town Planning" was the title of an interesting address by Humphrey Carver, A.R.I.B.A., at the annual meeting of the Royal Architectural Institute of Canada. He reviewed a number of interesting examples of town planning, mentioning among others "Democracity" in the interior of the great Perisphere at the New York World's Fair, the "ribbon town", Magnitogorsk, an industrial town in Russia zoned in ribbons, and many others. The importance of town planning at the present time was stressed, inasmuch as slum areas in a number of our larger cities could be reconstructed on a community basis.

The potential part being played by the government under the National Housing Act in defeating planned neighbourhoods was stressed. With indiscriminate erection of low priced houses under private ownership, it is almost impossible to co-ordinate construction into the very fine community planned construction which has been worked out on a large scale by experts in town planning and which has been put into actual fact in many parts of the world. The speaker asked "What has the Director of Housing done to see that all sub-divisions and projects opened up by the Housing Act are parts of planned neighbourhoods? What has the Department done to inform building promoters that this is a desirable public policy in the interests of real financial and social stability? And are we prepared to admit that the mythical sanctity of individual home ownership has been largely promoted in order to evade the obligations to plan and build on a community scale? It is impossible to obtain good group housing and neighbourhood planning while we are tied to the apron strings of an obsolete social philosophy."

We are not prepared to deprecate home ownership, which is one of the surest ways of preserving the spirit of community responsibility in the individual, but it does seem logical that the operation of this Act, under which already over sixty million dollars has been loaned on new construction (apart from the fifty millions under the Home Improvement Plan for the reconstruction of older homes), should be so controlled that it could be utilized to set up model communities rather than to perpetuate our present silly way of erecting homes in light- and space-wasting rows. What does not appeal to us particularly is that it is almost impossible for a hospital to obtain money under these plans for the construction of much needed facilities for serving the sick of the community.

Food Control for the Rural Hospital

Some Factors Involved in Planning and Purchasing

HELEN J. DREW, B.Sc.
Dietitian, Trail-Tadanac Hospital
Trail, B.C.

MEAL planning in any hospital involves consideration of certain general factors. The patient count and the number of staff members directly influence the flexibility and variety of the menu. The type of patient, whether long term as in a tuberculosis or psychiatric hospital, or short term, will have a direct bearing on the menu variations. Is the source of revenue, government, privately or municipally controlled? Are there many funds available for maintenance of the hospital? The district and location of the hospital will determine the variety of food stuffs, for if there are inadequate storage facilities and the market or source of supply means costly transportation charges, then certain fruits, vegetables and meats may not be available at all times of the year. Thus these factors, together with the characteristics and customs of the members of the community must receive consideration in planning the menu in any hospital and especially in the rural hospital.

No matter how many problems are involved in the management of each hospital menu, there are ways of easing the task of planning. Classified lists of menu suggestions, standardized recipes and information as to available products all contribute to make menu planning a pleasure rather than a burden. Then, too, there should be a close relationship between the food-worker and the buyer or business superintendent. Buying and storing of foods do most certainly concern the head of the food department, for she it is who must plan their wise and satisfying use.

In the dietary unit of the hospital, the menu is the centre of the wheel. The planning, preparing and serving of the food which involves purchasing, cost accounting, standardizing recipes and products, all radiate from that centre like spokes in a wheel. Upon the menu may depend the welfare and satisfaction of the patient, the cost of the food department operation and the amount of labour required by the actual food workers.

A satisfactory set of menus should be prepared for a definite period of time, such as one week, two weeks, or one month. It is even possible to repeat menus (with minor alterations) at four week intervals during the various seasons of the year. A planned menu considers the supplies available, provides for left-overs and cuts down waste. It gives a long view of the time and work involved in preparation; it anticipates and prevents repetition of foods served.

Depending upon the location of the small rural hospital, the foods available will vary throughout the year. A classified list of available fruits and vegetables, canned, fresh, or stored, facilitates menu planning. Whether the food worker has direct or indirect control of the purchase of her supplies, she must know her markets. Since she is the one who must produce the finished product from the material supplied, her opinion of those materials, if sincere and studied, should be invaluable to the purchaser.

Whether or not she is the buyer in the small hospital, the dietitian should study the source of supply of her foodstuffs. The quantities of staple goods necessary for the average small hospital may warrant purchase from a wholesale house. Whether buying meat, dry or green groceries, the various supply houses should be considered for quality, price and service. In rural districts where such products as eggs, butter, poultry and milk must be taken in "on account", it is essential that the food worker be quick to detect quality. Supplies which are necessarily used in small quantity only, may be purchased locally. It is good business to maintain local good will by buying from reputable vendors one month in turn.

A vegetable garden is a boon to the hospital situated in a district remote from great market centres (see illustrations). This may be just a small summer garden or a large scale truck farm, which may produce sufficient vegetables and fruits for a win-

(*Continued on page* 42)

The 12-acre vegetable garden from which the Provincial Auxiliary Mental Hospital at Claresholm, Alberta, obtains its winter supply of vegetables.

Miss Drew was formerly dietitian at the Provincial Auxiliary Mental Hospital, Claresholm, Alta.

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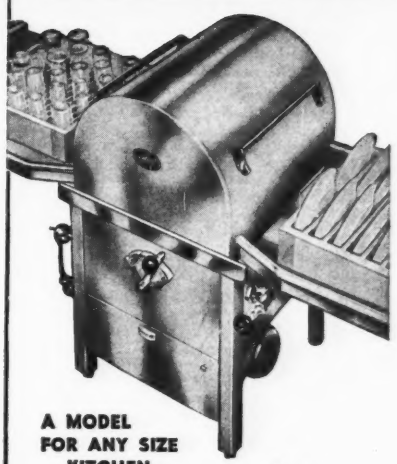

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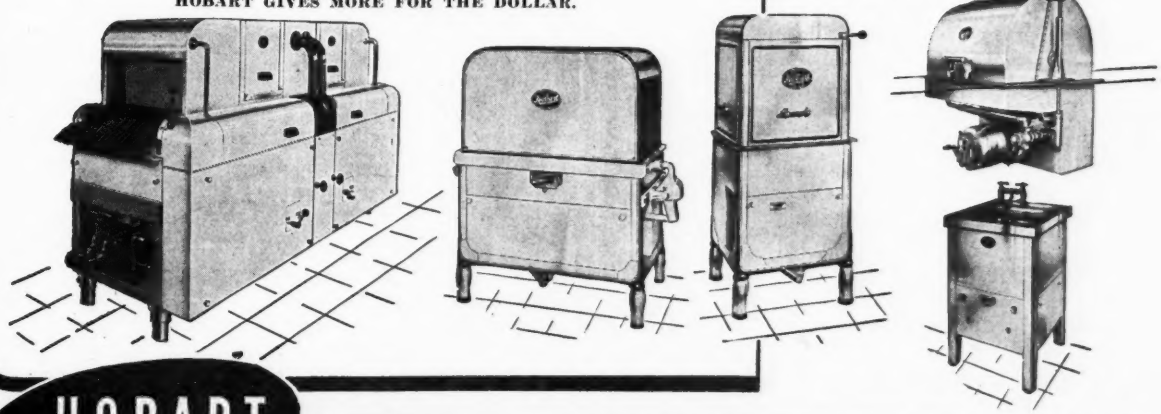

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With the Hospitals in Britain

By "LONDONER"

Dear Mr. Editor,

As the war progresses, conditions are changing and affecting hospitals in common with all other sections of the community. At the beginning of the war, Air Raid Precautions were the primary concern and although the phrase "A.R.P." is a good deal in colloquial use the position really is that the whole organization is devoted to Civil Defence.

"A.R.P."

The first step in Air Raid Precautions was to secure an effective "black-out". This was not an easy matter for hospitals. A combination of dark blue windows with yellow electric bulbs was effective for a time though it had a gruesome effect on the countenance of patients and staff besides spreading a depressing gloom. The colouring on the windows tends to fade and to require frequent renewal.

Where curtains were available a chink of light often appeared around the edge so that it was necessary to have a black border round the window. Moreover there was always a risk that an open window would blow the curtain about and so expose the light. In more than one area the local population have been convinced that the attacks on hospitals were due to lights showing in them and made their protests to the authorities. This may be due to the difficulty in believing that hospitals could be the subject of wanton attack and so honest minded folk sought a reason for it. However that may be, it has been really difficult to secure an effective "black-out". In a surprise visit with a colleague in the early morning we found one of the offending windows to be the matron's own bathroom!

Dimmed and shaded lights have been in use to such an extent that the medical and nursing staffs have had difficulty in attending to the requirements of the patients. Unless curtains are either lined or doubled there is a risk of light of normal standard penetrating to a sufficient extent to show a building lighted in the darkness, which has been intensified by the extinction of all forms of external lighting.

Location of Patients

Another precaution taken against air raids was the evacuation of upper floors, both of wards and nurses' homes. We started with a theory that the first floor about thirty feet from the ground was particularly risky on account of blast and there was a general movement to the ground floor. Few people now lay down any general propositions about the effect of blast. Verified records of varieties of incredible movements are innumerable. The chief protection has been the erection of cement blocks of walls protecting doorways and other vulnerable points which to a considerable extent superseded sandbags as the latter were seriously affected by the weather. Although some people now think that the first floor is less liable to danger than the ground floor both parties have found agreement in a general move to the basement which, whatever may be its disadvantages, is psychologically more comforting and has taken the place of any out-door shelters.

Mr. C. E. Bedwell, our British Correspondent, is here shown with his first grandchild, whose life was probably spared or, at least, who was saved from serious injury by the use of netting affixed to glass as shown in the background of this illustration. The use of this netting on glass is now becoming widespread in England as a reasonably effective measure to limit the danger of flying particles of glass.

Glass

Nevertheless glass still remains the chief cause of risk. For a hospital to have six or seven hundred windows broken in these days hardly deserves mention. Moreover the glass gets everywhere. A nurse told me that she actually found a piece lying inside an abdominal bandage; yet it had not scratched the patient. Not many are so fortunate, as a large proportion of the minor injuries are due to broken glass. The number of fragments after a row of shops or even of houses have had their windows blown out has to be seen to be believed. It is just scrunch, scrunch all the way as one walks along the road. The consensus is that a simple and effective measure of protection is provided by muslin pasted on the glass. It prevents the glass from disintegrating to the same extent if it is broken.

Fire Fighting

The result of the effectiveness of the "black-out" has been that the enemy has created light by the use of small incendiary flares sometimes containing explosives. They have been dropped in hundreds and, if they have obtained hold, there is sufficient light to help him on his way. It has been a feature of recent attacks that, as the flames were being fought, bombs were dropped into them. It will be appreciated, therefore, that air raid wardens and others originally concerned with precautionary measures have now become actively engaged in defence of life and property. Particulars of the actual accessories of stirrup pumps, buckets of gravel, etc., are available in official publications for the use of householders, but hospitals have prepared their own manual of directions for the effective organization

(*Continued on page* 46)

What One Eastern Hospital is Doing to Prepare For an Emergency

R. H. GALE
Asst. Superintendent
Saint John General Hospital

SHORTLY after the outbreak of war, and when blackout precautions were first instituted, we made certain arrangements, some of which have since been changed, but generally speaking the original arrangements still hold good.

One of the first matters to be considered was that of blocking out light, and various means were taken to accomplish this end. All blinds were checked to be sure that they were functioning properly, and certain windows that had no blinds were covered, while others were painted out with black paint or covered with a heavy black paper. Also, draperies which permitted light to show through were covered with a black cotton material of very fine weave. These curtains, so called, were rolled up and could be dropped readily when necessary.

We also made arrangements whereby some one member of the staff was responsible in seeing that all blinds were drawn at twilight and remained so throughout the night.

In addition, our engineering staff was instructed to pull the various switches on the several panel boards, or in other words, all light was cut off at the source. On the other hand, however, the switches controlling power to service the elevators and other power units were left on. All members of the night staff were provided with and carry at all times electric flashlights. These staff members include supervisors, orderlies and interns.

Originally we had candles, in small wooden blocks with holes in the centre as candle stands, supplied for rooms and wards. These have been removed as a fire hazard, as have also been all oil-burning lanterns. In their stead we have supplied the various departments with electric lanterns. These lanterns contain two dry cell batteries No. 6, each of 1½ volts. Three of these lanterns are kept in the office of the night superintendent and at night one each is placed in the Admitting Office, Out-Patient Department, and elevator, while others are distributed throughout the various floors and departments.

When the light is cut off at the panel board, we also cut off the current to our gas operated emergency lighting plant. In order to provide light for the operating rooms, we had constructed a number of mobile lighting units. These units comprise three dry batteries of 6 volts each which generate 180 watts, feeding three electric bulbs of 60 watts each, and are good for a period of four hours continuous burning. These batteries are in a box which is equipped with rubber-tired casters. The lighting unit has a goose-neck and stands some six feet, and at the end of the neck there is a large reflector within which there is a rosette containing the three bulbs of 60 watts each. One of these units is kept in each operating room, case room, and emergency operating room in the Out-Patient Department.

To summarize the above, we have taken all possible precautions to eliminate light showing outside the building, but on the other hand have equipped our staff and the special departments with portable lights, all of which are operated on batteries.

In addition to the above arrangements, we also provided a decontamination room at the entrance to the out-patient department. This was set up under the supervision of Dr. C. W. MacMillan, who was then the District Medical Health Officer here, but who is now the Chief Medical Officer of the province and stationed in Fredericton.

As this is a modern "fire proof" building, it has not been as necessary here as would have been the case in some hospitals, to make elaborate precautions against fire.

A Dining Room for Visitors

A special dining room for visitors is always much appreciated and usually obtains surprising patronage. The room illustrated is located in a sunny corner of the Private Patients Pavilion, Toronto General Hospital.

Selective Menu for Private Patient Service

Prepared by MARGARET KETCHEN, Staff Dietitian, Toronto General Hospital

Tuesday

Breakfast

Pomerang Juice Stewed Prunes
Fresh Pineapple
Cream of Wheat Red River Cereal
Shredded Wheat
Eggs Boiled or Scrambled
Grilled Bacon
Jelly
Toast or All-Bran Muffins

Dinner

Vegetable Soup or Lamb Broth
Individual Chicken Pie
Broiled Halibut — Lemon Butter
Mashed Potatoes
Buttered Corn New Spinach
Pickled Beet Salad
Steamed Blueberry Pudding — Sauce
Banana Sponge Junket
Vanilla Ice Cream
White or Hovis Bread

Supper

Cream of Celery Soup
Salad Plate — Cold Roast Beef
Grilled Lamb Chop
Macaroni and Cheese
Lettuce Hearts
Fresh Fruit Salad
Date Squares — Strawberries
Orange Jelly Baked Custard
Tea Biscuits
White or Whole Wheat Bread

Thursday

Breakfast

Orange Juice Grapefruit
Stewed Peaches
Cream of Wheat Sunera
Puffed Rice
Grilled Bacon
Eggs, Boiled or Poached
Marmalade
Toast or Swedish Tea Ring

Dinner

Split Pea Soup or Beef Broth
Broiled Steak — Gravy
Grilled Sweetbreads — Mushrooms
French Fried Potatoes
Creamed Cauliflower Vegetable Macedoine
Grated Carrot and Raisin Salad
Steamed Fruit Pudding
Lemon Mist — Whipped Cream
Chocolate Ice Cream Junket
White or Whole Wheat Bread

Supper

Cream of Corn
Salad Plate — Cold Tongue
Chicken a la King
Baked Stuffed Potato — Bacon
Lettuce Hearts
Spring Salad
Macaroons — Cherries
Pineapple Jelly Baked Custard
English Muffins
White or Whole Wheat Bread

Saturday

Breakfast

Orange Juice Applesauce
Fresh Pineapple
Cream of Wheat All Bran
Red River Cereal
Grilled Bacon
Eggs, Boiled or Omelette
Marmalade
Toast or Graham Muffins

Dinner

Julienne Soup or Chicken Broth
Roast Beef — Yorkshire Pudding
Creamed Calve's Sweetbreads
Roast Brown Potatoes
Harvard Beets Green Peas
Cole Slaw
Date and Marshmallow Roll
Chocolate Blanc Mange Junket
Vanilla Ice Cream
White or Whole Wheat Bread

Supper

Cream of Carrot
Grilled Calve's Liver and Bacon
Broiled Salmon Trout — Lemon Butter
Creamed Mushrooms en Casserole
Lettuce Hearts
Sliced Tomato Salad
Walnut Squares — Plums
Cherry Jelly Baked Custard
Japanese Rolls
White or Whole Wheat Bread

Wednesday

Breakfast

Apple Juice Stewed Rhubarb Orange
Cream of Wheat Old York Cereal
Bran Flakes
Eggs Boiled or Omelette
Grilled Bacon
Jam
Toast or Blueberry Muffins

Dinner

Creole Soup or Consomme
Breaded Veal Cutlet — Sauce
Stewed Chicken — Tea Biscuits
Parsley Potatoes
Harvard Beets Green Peas
Celery and Radishes
Individual Apple Pie — Cheese
Coffee Charlotte Russe Junket
Vanilla Ice Cream — Butterscotch Sauce
White or Whole Wheat Bread

Supper

Cream of Asparagus Soup
Salad Plate — Cold Cuts
Grilled Pork Sausage — Applesauce
Broiled Fillet Sole — Lemon Butter
Lettuce Hearts
Jellied Tomato and Cottage Cheese
Chocolate Cake — Fruit Cup
Grapefruit Jelly Baked Custard
Scones
White or Whole Wheat Bread

Friday

Breakfast

Grapefruit Juice Stewed Apricots
Baked Rhubarb
Cream of Wheat Cubs
Old York Cereal
Grilled Bacon
Eggs, Boiled or Shirred
Jam
Toast or Cinnamon Coffee Cake

Dinner

Scotch Broth or Consomme
Roast Veal — Jelly
Broiled Lake Trout — Lemon Butter
Parsley Potato
Buttered Broccoli Julienne Carrots
Sliced Cucumber — French Dressing
Lemon Chiffon Tart — Whipped Cream
Fruit Jelly Junket
Peppermint Ice Cream — Chocolate Sauce
White or Whole Wheat Bread

Supper

Cream of Celery
Vegetable Salad Plate
Grilled Ham — Sauce Piquante
Poached Eggs — Bacon
Lettuce Hearts
Perfection Salad
Harvard Cake — Baked Apple
Grape Jelly Baked Custard
Hot Rolls
White or Whole Wheat Bread

Sunday

Breakfast

Apple Juice Stewed Prunes
Grapes
Cream of Wheat Sunera Cereal
Cornflakes
Grilled Bacon
Eggs Boiled or Fried
Honey
Toast or Bran and Date Muffins

Dinner

Fruit Juice or Consomme
Roast Chicken — Jelly
Boiled New Potato
New String Beans Vegetable Macedoine
Lettuce Hearts — Thousand Island Dressing
Butterscotch Tart — Whipped Cream
Orange Charlotte Russe Junket
Vanilla Ice Cream
White or W. W. Bread Hot Rolls

Supper

Cream of Tomato
Salad Sandwich Plate — Toasted
Cheese Roll
Creamed Fresh Asparagus on Toast
Lettuce Hearts
Swedish Pastries — Peaches
Grapefruit Jelly Baked Custard
Raisin Bread
White or Whole Wheat Bread

"Please Indicate 'Double Portion' if larger servings are desired" is printed on all menus.

Choice of Milk, Tea, Coffee or Cocoa allowed at all meals.

Recipes will be supplied on request by Florence W. Stacey, "The Canadian Hospital", Toronto.

Suggested Menu for Nurses and Staff

Prepared by MARJORY C. LIPSEY, Staff Dietitian, University Hospital, Edmonton.

Breakfast	*Dinner*	*Supper*
Orange Halves Cream of Wheat Bacon Rolls Peach Jam	Puree of Pea Soup Boiled Beef Gravy Horseradish Parsley Potatoes Mashed Turnips Strawberry and Banana Shortcake with Whipped Cream	Baked Macaroni and Cheese Sweet Mixed Pickles Raw Carrot Sticks Apple Sauce Oatmeal Ice Box Cookies
Tomato Juice Sunny Boy Cereal Soft Cooked Eggs Rolls Marmalade	Vegetable Soup Baked Ham with Gooseberry Jam Creamed Potatoes with Pimento Buttered Asparagus Raisin Pie	Hamburger Patties in Buns Mustard Pickle Relish Kernel Corn Shredded Lettuce Mayonnaise Loganberries White Cake, Chocolate Icing
Stewed Apricots Rolled Oats Scrambled Eggs Rolls Strawberry Jam	Tomato Broth with Barley Breaded Veal Cutlets Sweet Relish Hashed Brown Potatoes Buttered Green Cabbage Steamed Gingerbread Pudding Marshmallow Sauce	Assorted Cold Meats Hot Potato Salad Lettuce Garnish Sliced Beet Pickles Pears Bran Muffins
Grapefruit Juice Smiles Bacon Rolls Honey	Baked Bean Soup Roast Beef Gravy Creamy Mashed Potatoes Wax Beans O'Brien Creamy Rice Pudding Spiced Hard Sauce	Cream of Tomato Soup Salad Plate Devilled Egg Canadian Cheese Lettuce Radishes Sl. Cucumber Boiled Dressing Apricots Pumpkin Cake, Brown Sugar Icing
Orange Halves Cream of Wheat Fried Eggs Rolls Marmalade	Potato Soup Hot Salmon Loaf Tartar Sauce Scalloped Potatoes Carrots and Peas Butter Tarts	Hot Vegetable Plate Parslied New Potatoes Cauliflower au Gratin Buttered Spinach Cabbage Relish Lemon Snow Pudding Strawberry Sauce
Apple Juice Rolled Oats Bacon Rolls Cherry Jam	Cream of Corn Soup Liver with Onions Creamy Mashed Potatoes Scalloped Tomatoes Chocolate Cream Pudding Whipped Cream	Hot Roast Beef Sandwich Gravy Mustard Pickles Mixed Fresh Vegetable Salad Rhubarb Lemon Crumb Cake
Stewed Prunes Choice of Dry Cereal Poached Eggs Rolls Crabapple Jelly	Chicken Broth with Vegetables Roast Veal Gravy Dressing Browned Potatoes Buttered Beats Vanilla Ice Cream Caramel Sauce	Tunafish a la King on Toast Sliced Tomatoes Fruit Cup Ranger Cookies
Grapefruit Juice Rolled Oats Bacon Rolls Marmalade	Julienne Soup Baked Meat Loaf Gravy Sweet Mixed Pickles Creamy Mashed Potatoes Succotash Apple Pie with Cheese	Economy Omelet Spanish Sauce Buttered Asparagus Sliced Cucumber Sliced Bananas Spice Cake, Cocoanut Icing
Orange Halves Cream of Wheat Fried Eggs Rolls Raspberry Jam	Lentil Soup Roast Beef Gravy Parsley Potatoes Buttered Carrot Strips Rhubarb Crisp	Jellied Veal Loaf Potato and Vegetable Salad Lettuce Radishes Jelly Roll with Whipped Cream
Apple Juice Smiles Baked Sausages Rolls Marmalade	Carrot and Rice Soup Meat Pie Creamy Mashed Potatoes Cole Slaw Vanilla Cream Pudding Loganberry Sauce	Sliced Tomatoes on Toast Cheese Sauce Side Bacon Peaches Chocolate Cake
Tomato Juice Rolled Oats Soft Cooked Eggs Rolls Bramble Jelly	Cream of Vegetable Soup Pork Tenderloins Apple Sauce Creamed Potatoes Mashed Turnips Ginger Pear Molasses Cake Lemon Sauce	Cottage Cheese with Peaches and Sliced Pineapple Lettuce Fruit Dressing Celery Curls Peanut Butter Sandwiches Cherry Jello Custard Sauce Butterscotch Ice Box Cookies
Mixed Fruit Juice Corn Meal Pancakes with Syrup Rolls Apricot Jam	Lima Bean Soup Baked Halibut Celery Sauce Creamy Mashed Potatoes Buttered Spinach Date Butterscotch Tapioca Homo	Poached Eggs on Toast Beet Relish Buttered Peas Strawberries Rolled Oats Muffins
Stewed Prunes Gillespie Maid Bacon Rolls Marmalade	Scotch Broth Boiled Beef Gravy Creamy Mashed Potatoes Buttered Onions Toasted Coconut Cream Pie	Cold Sliced Tongue Pan Fried Potatoes Cabbage, Pineapple and Marshmallow Salad Red Plums Marble Cake, White Icing
Apple Juice Choice of Dry Cereal Fillets of Finnan Haddie Rolls Plum Jam	Fruit Cup Baked Ham Spiced Pineapple Rings Scalloped Potatoes Buttered Green Beans Chocolate Cake a la Mode	Devilled Eggs Shrimp in Tomato Aspic Lettuce Dressing Finger Rolls with Chicken and Celery Filling Pears Hot Orange Marmalade Biscuits

A variety of prepared cereals is available each morning for breakfast.
Milk is placed in jugs on each table at every meal.
Coffee is served for breakfast, tea for dinner and supper.
Recipes will be supplied on request by Florence W. Stacey, Dietetics Editor, "The Canadian Hospital", Toronto.

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Catering In War-Time

British Hospitals Make the Most of Their Rations

By WINIFRED YEOMANS

(The complete article appears in "Hospital and Nursing Home Management" for April and contains a number of war-time recipes for soups, vegetable dishes and savouries. The following three recipes are excerpted by way of illustration.—F.W.S.)

FOR those who are not yet won over to the urgent necessity of catering along entirely different lines from the old days of superabundance and limited taste, meal-planning and kitchen supervising must be one long headache. But the wise caterers and cooks who have, for some time past, been consistently endeavouring to alter the dietary habits of their hospital—introducing greater variety, a spirit of adventure in a wide use of vegetables and a lessening reliance upon plain meat dishes—are now reaping their reward. *Their* people are in training for war-time feeding and are gratefully ready to eat with relish what is provided for them.

We must stop grumbling about the foodstuffs we cannot get, and be willing to use with skill and eat with gratitude such produce as can be grown and bought for our consumption. It will do us a lot of good. Already people, who two years ago would toy critically with a steak and tomatoes and argue for ten minutes about the sweet course, may be seen clearing up to the last crumb a meal composed of vegetable cutlet, carrot, potatoes and gravy, followed by a sugarless date pudding, or perhaps only coffee and a biscuit. And they are feeling the better for it. There is no doubt that we have been eating too much and too often. Frequently the pangs of hunger were a form of indigestion due to the stomach never being at rest, or to its "high acid" state caused by too large an intake of protein. When the diet is rich in mineral salts and its energy is derived from the vegetable starches, there results an inner cleanness and inner contentment and a freshness and a longer period without hunger, which is of great benefit.

Food is a Munition of War

It is just as wasteful and wrong to eat more than we really need, to cater and cook in ignorance or to neglect the proper care and use of perishable stores as it would be to throw good food into the fire. Here is another special reminder to caterers and cooks. Do not attempt to cater on pre-war lines, come boldly out, enlist everybody's co-operation. Do not shut your eyes to extravagance or stubborn resistance to the needs of the day and to war-time requirements. See that *your* side of the business is as far above reproach as you can possibly make it, and then you will be in a strong position to deal with the gluttons, the selfish, the unadaptable and the faddists.

Food should not be left on the plates at table as often happens when people are finicky. A few spare plates should be set out on each table, and on these the staff should put any food from their own plate which is not to their liking or is in excess of their requirements *before* they commence to eat. These plates of food should then go into the kitchen and be treated as clean leftovers and *not* put into the swill tub as leavings. Both the catering and the cooking staff should make it their business to watch this.

The Ministry of Food in the "Kitchen Front" section, is continually working on diets and recipes for our help and guidance and has a special department dealing with correspondence. Besides the food facts published in the press, the Ministry supplies a number of other recipes and menus, all of which are exhaustively tested out in its own kitchen. We expect the Ministry of Food to see us through, and therefore we cannot do better than go wholeheartedly and intelligently hand in hand with it.

Potato Pastry

4 lbs. flour; 2 lbs. fat; 2 lbs. dry mashed potatoes; water or milk and water; salt; 4 level teaspoons baking powder.

Rub fat into flour, salt and baking powder, rub in dry mashed potato. Mix to a *stiff* dough with the liquid. Knead and roll out smoothly. Use as ordinary pastry.

Country Cream Pie

Collect all the root vegetables possible, with plenty of potatoes and carrots for the bulk and a little onion or leek. Both kale or sprouts and cauliflower may be included. Steam or conservatively cook the bulk of carrots and potatoes, and the rest of the vegetable dice or slice small and cook in as little stock or water as they need.

When the potatoes and carrots are cooked, beat them to a fluffy texture with a little hot milk and margarine. Season with salt and pepper and nutmeg and keep hot. Strain off the other vegetables and make a good sauce with the liquor, sharpen this sauce with a little vinegar or lemon if you have it, and add a generous quantity of chopped fresh parsley. Grate in scraps of cheese if you have any.

Line greased dishes with the potato and carrot cream, leaving a good hollow in the centre. In this hollow put your vegetable mixture, dress with the sauce. Cover with the potato and carrot cream, decorate the surface with a wet palette knife or rough up with a fork, bake through and brown off nicely. Send to table with the rest of the sauce.

This makes an excellent supper dish or an accompaniment to baked fish, sausages or egg and bacon for dinner. The vegetables and the flavourings should be varied from time to time: herbs, a little curry powder, tomato puree or new peas and beans when in season.

Ham Patty

This is an old-time country favourite which is delicious and both time-saving and economical.

Use up the remains of a piece of boiled bacon, scraps of pork, small bacon pieces such as can be bought cheaply. Put them through the mincer with carrots and spring onions, an apple, a little oatmeal and some cooked potato. Mix well, add for moisture

(*Concluded on page* 48)

Here and There

By THE EDITOR

Royal College of Surgeons Museum Wrecked

THE hundreds of staff doctors in our hospitals who have visited the fascinating museum of the Royal College of Surgeons in London will regret to hear that it has been badly wrecked by high explosive bombs dropped by the Huns. This famous medical museum, from which Sir Arthur Kieth and many other internationally known lecturers drew so much of their material, was crowded with objects of consuming interest to anyone interested in medicine or the basic sciences. The official description of the damage sustained has not been received, but press notices would indicate that a number of valuable objects in the museum have been destroyed. Among those mentioned is the mummy of Ra Nefer, an Egyptian nobleman who lived about 4000 B.C., making this the oldest mummy known to exist. Lost also were some anatomical specimens from the body of Napoleon Bonaparte and the bones of Queen Berengaria, consort of King Richard of the Lion Heart. This great collection, started one hundred and fifty years ago by the illustrious Dr. John Hunter, and purchased by the nation in 1795, apparently has been burned or buried beneath the blasted masonry, reference being made to the destruction of the osteology, physiology and pathology sections of the Royal College.

* * *

Another Aspect of the Blockade

The price of fruit and vegetables has always been higher in England than the corresponding Canadian and American prices, but a press report from London dated May the 10th gives prices which would make any Canadian dietitian tear her hair. Strawberries are priced at 20 cents *each*—which, we imagine, puts the favourite dish of "strawberries with clotted Devonshire cream" well beyond the pocket of most Englishmen. Cucumbers are 50 cents each, tomatoes 30 cents each, lettuce 20 cents a small head and mushrooms 60 cents a pound.

Acquiring a Scotch Flavour

It is interesting to note that the publication address of "Hospital and Nursing Home Management," the popular British hospital magazine, is "Cressfield, Ecclefechan, Lockerbie, Dumfriesshire. This is just typical of endless firms and organizations in Great Britain which have found it necessary to move their head office and plants from the big cities like London and Liverpool out to small towns and villages where there is decreased danger to some extent from barbarian bombs.

* * *

Tea for All at the Buffalo General Hospital

At the Buffalo General Hospital, staff, patients and their visitors are invited to "drop in for a cup of tea" between four and five o'clock on week days. Tea and cookies are served in the solarium and sometimes there's music from the Hammond organ played by one of the personnel.

The administrator, Dr. Fraser D. Mooney, says that they "wouldn't think" of discontinuing this pleasant practice. After a year and a half the administration believes that this afternoon pick-up adds considerably to the efficiency of the staff and that it's a strong point in a public relations programme.

* * *

A Logical Inference

A member of our editorial board vouches for the following incident. Twins well along in middle life and badly in need of a liberal application of soap, water and the razor, were by a coincidence, admitted on succeeding days. Exhausted after his labours to make the first twin presentable, the orderly found himself on the following day confronted with an even more formidable task. He could not help but express to twin number two that he was even dirtier than his brother. "Well", replied number two, "He should be a bit cleaner than I am. He was a patient here four years ago."

An Albino Negro

A pair of unusual Negro twins, eight months old, are now in New York, being studied by students of genetics. One of these Negro twins from North Carolina is a complete Albino, whereas her small brother is a normal Negro child. The fact that the mother and father are Negros and that the twin brother shows normal Negro pigmentation makes its white skin and white hair and light eyes all the more startling.

* * *

A $13,000 Cough

The Republican National Committee is now wrestling with the problem of whether to pay or not to pay a $13,000 fee submitted for looking after Wendel Willkie's throat during the presidential campaign by a Beverly Hills otolaryngologist. It would appear that the specialist travelled with the candidate armed with the necessary atomizers and applicators to help preserve Mr. Willkie's over-strained voice during those hectic days. It is the contention of the specialist that his normal fee when away from his lucrative Hollywood practice is $500 a day. Mr. Willkie, it is said, has offered to pay the bill himself, but the national organization considers that this is an obligation that might properly be assumed by the Committee.

* * *

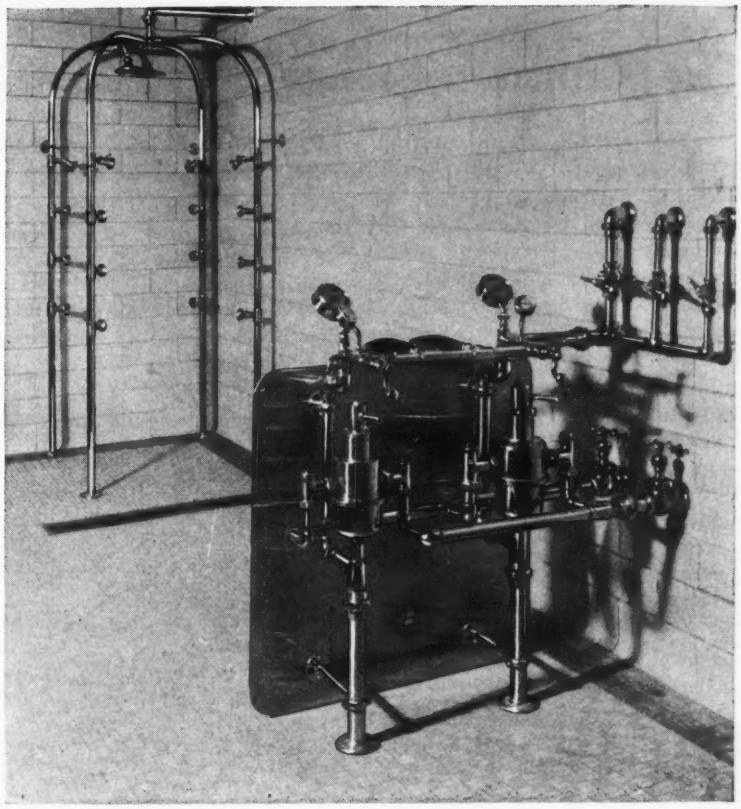
The Least We Can Do Is Lend

Over in England there is a radio comedian who sets his rationed listeners laughing with recipes like the following:

"Take a large sirloin steak, smother it liberally with onions, spread with a thick coating of grated cheese, and fry in deep butter."

If we could just get the amazing spirit of these people who can treat their privations with a smile, albeit a grim one sometimes, we Canadians, who can get all the steak and onions and butter we want, would certainly decide to increase the size of our Victory Loan Bond purchases this month.

"Now We're Up-To-Date on Hydrotherapy!"

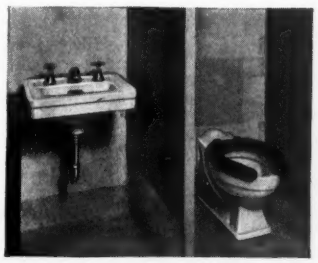


"it is really surprising to see how the effectiveness of our hydrotherapeutic technique has increased since we installed Crane-Equipment in our hospital."

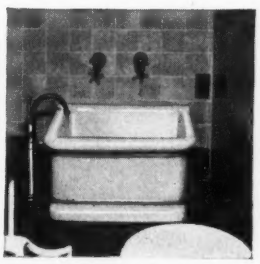
WATER—one of the oldest and most effective therapeutic measures known — is given new usefulness, new efficiency in symptomatic and curative treatment — when you install Crane hydrotherapeutic equipment.

As an example, the Crane hydrotherapeutic shower and control table, illustrated above, enables the operator to obtain circulatory reactions considered best for the patient, because it maintains extremely accurate control of water temperatures and pressures. Through two flexible "Scotch" or alternating douches, water of two distinct temperatures can be alternately directed to the patient with great rapidity. Easily-read dial thermometers and pressure gauge make proper control easy.

Crane offers the modern hospital a complete line of plumbing equipment for the hydrotherapy and physiotherapy departments ... equipment designed with the aid of surgeons and scientists, and backed by the 85-year Crane reputation for quality. For complete information, see your architect, builder or master plumber or write for information.



Crane offers complete equipment for the hydrotherapy or physiotherapy department.



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Crane 6506 Continuous Flow Arm Bath.

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The Coming Census

DURING the month of June the regular decennial census of the Dominion will be taken by a corps of census takers who will scour the entire country to ascertain how many people we have, how old they are, what they are doing, where they came from and what language they speak.

The census is more than simply an enumeration of our population. Its eight assorted schedules will cover not only population but also agriculture, horticulture, live stock, housing, merchandising, institutions and a special one on blindness and deaf-mutism. Even the chickens and bees will be counted, although we did not note any space for the enumeration of fleas on Rover.

The census is really a most vital activity of the government. By it representation in our federal parliament is fixed. It is a basis for an analysis of our knowledge of social and economic conditions in this country. The wellbeing of the state —physical, moral, economic—together with its ills in any form can be apprehended and interpreted only through the medium of population statistics. It is the chart by which the government directs national affairs.

Census taking dates from the dawn of civilization but the credit of taking the first census of modern times belongs to Canada. The year was 1666; the census was that of the Colony of New France. There had been earlier records of settlement at Port Royal (1605) and Quebec, (1608), but the Census of 1666 was a systematic "nominal" enumeration of the people, (i.e., a record of each individual by name), taken for a fixed date, showing the age, sex, place of residence, occupation and conjugal condition of each person. Altogether this Census recorded 3,215 souls. When it is recalled that in Europe the first modern Census dated only from the eighteenth century (those of France and England from the first year of the nineteenth), whilst in the United States no Census of the country as a whole was taken before 1790, the achievement of the primitive St. Lawrence Colony in instituting what is to-day one of the principal instruments of Government in every civilized community may call for more than passing appreciation.

The population in institutions will be enumerated in the regular way by means of the Population schedule proper, but it is intended that a special inquiry shall be handled direct from the Bureau with the heads of institutions.

In connection with these some-

what elaborate and searching inquiries the following points should be clearly understood: (1) no question has been inserted merely because the information would be interesting, but only because it has a bearing on basic social or economic conditions; and (2), the answers given by the individual are absolutely confidential, every employee of the Census being under oath and penalty against revealing any individual item, the Bureau of Statistics itself being forbidden to issue any statement that would lay bare any personal matter.

The success of the Census depends largely upon the co-operation of the people. It is taken for the benefit of the community as a whole and therefore directly or indirectly to every member of the community. Never before has there been the like need for census information. Therefore, the Census merits the support of each and every citizen as a patriotic duty. People are requested to assist in this great national undertaking to the fullest extent by freely and correctly furnishing the information desired.

Rising Costs at Kingston

Cost of food supplies has not increased in the same proportion as that of medical supplies, but even a small increase on the 600,000 meals which are served each year brings a substantial final total. Milk alone will account for an annual increase of $1,400. Gauze has increased about 35%. All glassware and surgical instruments have been substantially increased in cost. A 5½" tissue forcep which cost 90c prior to the war, now costs $2.25. Drugs are up about 15%.

Congratulations to British Columbia Association Secretary

Mr. J. H. McVety, secretary-treasurer of the British Columbia Hospitals Association, has been appointed to administer the Unemployment Insurance Act for the Pacific region. He has been spending some time in Ottawa in connection with his new duties.

Guelph Doctor Appointed Chief Surgeon for R.C.A.F.

Squadron Leader L. H. Leggett of Guelph, senior medical officer at the St. Thomas Air Training School since last January, is now in charge of a large new hospital of the R.C.A.F. at an eastern port. In addition to being head of the hospital, Squadron Leader Leggett has been appointed Chief Surgeon for the R.C.A.F. Squadron Leader Leggett was, before the war, on the staffs of St. Joseph's and the General Hospital at Guelph.

Belleville Hospital Head Named

J. G. Barclay, Phm.B., pharmacist at the Belleville General Hospital, has been appointed acting superintendent during Mr. Gordon Friesen's leave of absence. Mr. Friesen is a Pilot Officer with the R.C.A.F.

Addition to Salmon Arm Hospital Opened

National Hospital Day was celebrated at Salmon Arm, British Columbia, by the opening of the new addition to the hospital. The new wing provides both private and public ward accommodation for obstetrical patients as well as case room, nursery and service rooms. Final cost is estimated at about $9,000.

Food Control in Rural Hospitals

(*Concluded from page* 26)

ter's use. A well constructed root-house will soon pay for itself in the saving accrued from "home-grown" vegetables, bringing variety and freshness to an otherwise drab institutional table.

Quantity buying of canned goods for which adequate storage of the proper type is offered may be most advisable. Interesting price savings alone are not enough as a result of quantity purchasing. One must be certain that storage facilities are right and one must have first hand knowledge concerning amounts and uses for the product required over a unit period in order to insure efficient and economical quantity buying.

Perhaps more than ever in the small hospital, refrigeration is of prime importance in food control. For example, large amounts of meat will not keep in an ordinary storage refrigerator, the door of which is frequently opened and closed throughout the day. Infrequent deliveries in the rural situation mean storage of other perishables such as butter, milk and eggs. The risk of contamination and loss makes proper refrigeration indispensable.

Food control is as important in good hospital administration in the small rural hospital as in the large city institution. Based on sound principles of good management, the efficient, economical operation of the food service in the rural hospital is equally possible.

Infant Identification Bead Sets Now Duty-free

For some months it has not been possible to import infant identification bead sets as importation regulations prevented the importation of the material from which the beads were made. Representations were made to Ottawa by the Canadian Hospital Council with respect to this article. In accordance with the Budget Resolutions effective April 30th, 1941, infant identification bead sets including cases and integral parts thereof, are admissible free of duty under tariff item 476a when for the use of any public hospital. Although free of duty and of sales tax when purchased for the sole use of any public hospital and not for resale, there is payable the War Exchange Tax of 10%.

Crabapples, plums and small fruits, gooseberries, currants and raspberries are grown in the orchard at the Provincial Mental Hospital, Claresholm.

Canadian Nutrition Problems

(*Continued from page* 15)

nutritive values can be seriously impaired by improper cooking. Last, but not least, is the provision of information regarding *economical purchasing*. Especially great is the need for this type of education among families with limited purchasing power. There is an urgent need for an intensive, national undertaking to provide information about wise and economical choice of foods. Several organizations now exist which could co-operate to do this work admirably.

Since these Canadian surveys have shown that three outstanding deficiencies exist it is essential to consider, particularly, what can be done to correct these mistakes. We rely upon two foods, mainly, to supply calcium; these are milk and cheese. A number of false impressions have tended to limit the use of these foods. *Milk* has been thought to be fattening and has been eschewed by people who want to stay thin. Any food is, of course, fattening. Milk is actually less so than many other foods. Milk is erroneously considered to be an expensive food. It is a cheap source, in comparison with practically all other foods, of calcium, protein and several vitamins. Milk should be regarded as a "must" food, particularly for children. A popular misconception is that *cheese* is constipating; no physiological evidence is available to substantiate this and it should be corrected. Too frequently cheese is only used as a flavouring and is not given the place it deserves. Cheese is a cheap source of calcium and of protein and could be used with advantage, especially by low-income families.

The most glaring deficiency shown to exist in Canada is of that group of vitamins known as the *B complex*. These substances are found in whole grains, in meats, eggs, milk and some vegetables. *The cheapest source is whole wheat.* In the process of making white flour four-fifths of the vitamin content of the wheat berry are removed; white flour is a poor source of the B vitamins. Bread is a staple article of diet and low income families use large amounts because it is low in price. Nine-tenths of the bread used in Canada is white bread, low in vitamin content. Canadians are not securing sufficient of those vitamins which are richly present in Canada's most important crop. At present we have in storage 350 million dollars worth of wheat containing vitamins which our people need. This situation presents a challenge. If milling processes can be altered so that the vitamin content of wheat is preserved in the flour every citizen will benefit.

Attention should be given to seeing that women receive greater supplies of foods supplying *iron*. Women have a greater requirement for this element than have men. Economical sources of iron are molasses, whole grain products, and many common vegetables.

An improvement in Canadian food habits should mean a betterment of markets for Canadian farm

(*Continued on page* 48)

Present Day Need Puts Dietitian in Vanguard

(*Concluded from page* 20)

Common Complaints

What of the challenge to find the best answer for certain of the general complaints we frequently hear of our graduates:

1. Lack of adequate preparation in institution management subjects.
2. Lack of basic fundamentals of scientific food preparation.
3. Lack of a realistic concept of "orders".
4. Lack of awareness of the place "costs" play in their work.
5. Lack of skill in demonstrating their assets.
6. Lack of self-discipline, fundamental character traits, and a becoming self-humility in the successful administrator.

Many of our college graduates are well trained, with splendid personal assets; but these are often offset by the possession of one or more of the named weaknesses, which makes for a poor executive.

The college programme of four years cannot provide sufficient practice for their students to gain the much-needed confidence in the practicality of their theoretical knowledge. The proving ground must be found in the student courses of hospitals, commercial organizations and nutrition clinics.

C.D.A. Hospital Graduate Course

Briefly, the Canadian Dietetic Association Hospital Graduate Course is given in hospitals approved by the American College of Surgeons and having at least one hundred and twenty-five beds; dietary staff to consist of a director and at least one assistant dietitian, who are active members of the Canadian Dietetic Association. Entrance requirements —Bachelor's Degree from a recognized School of Household Science, with a major in Foods and Nutrition as prescribed by the Committee on Preliminary College Education. At least two students to be enrolled; the course varies in length from eight to twelve months. On completion of the course, a report of work is to be sent to the director of the school from which the student graduated. Experience is gained in administration, diet therapy, infant and child feeding and teaching experience. Affiliations are arranged so that a variety of experience may be gained; for example, in a small hospital where there is a combination of housekeeping and dietetics. At present there are fifteen such student courses tentatively approved by the Canadian Dietetic Association.

There are several opportunities of gaining commercial experience. One in particular is the course given at Hart House, University of Toronto, where the entrance requirements are similar to those of students taking hospital work. The length of the course is approximately eight and one-half months.

The object of this course is to provide an opportunity for Household Science graduates, who are interested in commercial dietetics and who definitely evidence administrative ability, to gain practical experience in the various phases of the work and to develop an understanding of major administrative problems.

Nutrition clinics are just now formulating courses in collaboration with several of the larger hospitals.

In all courses providing training for the dietetic profession the student should be given every chance to show her initiative and her power of organization, and she should be provided opportunity to solve problems which demand judgement and independent thinking.

Horace Mann has said: "Higher education should properly concern the whole individual and not the mind alone."

References:
(1) Journal of the American Medical Association, May 21, 1939.
(2) Mary W. Northrop, Medical Women's Journal, July, 1937.

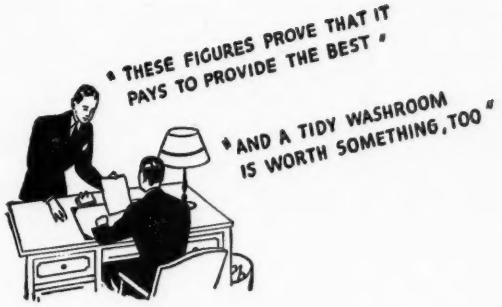
The Ontario Plan for Hospital Care has issued the above sticker, reproduced here in actual size, for the use of hospitals who could place one of the stickers on accounts issued to patients, on the back of envelopes of outgoing mail, etc. Hospitals desiring a supply of these stickers can obtain such from the headquarters of the Plan at the Excelsior Life Building, Toronto.

Residency at Victoria Hospital, London

The Department of Radiology offers a three year course for training in roentgen interpretation and therapy and radium therapy combined with training in gross and microscopic pathology.

The first year's service will begin on July 1st, 1941. It is required that persons applying for this service have at least one year's post-graduate training in either medicine, pathology, or general internship. Quarters in the hospital will be furnished and a salary of $25.00 per month for the first year will be allowed.

The director of the department is Dr. William W. Bryan.



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COMING CONVENTIONS

June 12-14—Second Hospital Trustees' Conference, University of Chicago.
June 16-20—Catholic Hospital Association, Philadelphia, Pa.
June 21—Annual Meeting Canadian Dietetic Association, Toronto.
June 23-27—Canadian Medical Association, Winnipeg.
June 25-26—Prairie Provinces Conference, C.H.A. St. Boniface, Manitoba.
July 2-3—New Brunswick Hospital Association and Hospital Association of N. S. and P. E. I. (Joint Meeting) Pictou, N. S.
August 13-27—Institute on Hospital Administration, Chicago.
September 10-11—Canadian Hospital Council, Montreal.
September 15-19—American Hospital Association, Atlantic City.
October 8-10—Ontario Hospital Association, Royal York Hotel, Toronto.
October 20-31—Second New York Institute for Hospital Administrators, New York.

With Hospitals in Britain

(*Concluded from page* 28)

to meet the particular needs of each building. It is a very different matter, for example, to combat incendiaries falling on flat roofs to what it is on the gables of an old building where getting from one to another in itself is a hazardous enterprise. The keynote of such schemes is that fire watchers on the roof give warning to different groups available on call to come into action at different points.

Administrator Takes Stock

(*Concluded from page* 16)

ation instead of leaving the criticism of a more or less tasteless meal to be borne by the dietitian.

We in Canada are fortunate in having our Canadian Dietetic Association. It is composed of leaders in this profession who have wisely adopted standards for membership that should assure to our hospitals competent and experienced dietitians who, if given the proper authority, can give to their respective hospitals an adequate, scientific and reasonable food service.

Nothing has been said in these brief remarks of the many opportunities for nutritional education in the out-patient departments, welfare federations or relief departments. A broad field is opening up here, and the continuance of the war will make countless demands on those whose interest is the field of dietetics and nutrition.

Hospital Plan Sets Record Enrolment

The largest single enrolment in the history of hospital and medical pre-payment care plans is now underway in Detroit at the Chrysler Corporation and Briggs Manufacturing Company.

The plans, which provide for complete hospital and surgical care, are being made available to 300,000 employees and their families through the corporations.

The two service plans, hospital and medical, are now protecting more than 350,000 people throughout the state against the unpredictable hazards of hospital and medical care costs, it was reported.

Price Trends

	Yearly Average 1940	March 1940	February 1941	March 1941
	(On basis 1926 = 100)			
Building and Construction Materials	95.6	94.7	100.1	100.6
Consumers' Goods (Wholesale)	83.4	83.0	85.7	86.2
	(On basis 1932-1939 = 100)			
Cost of Living	105.6	104.6	108.2	108.2

Catering in War-Time

(*Concluded from page* 36)

a little stock or gravy, season with salt and pepper as required, and ring the changes in flavour with a light sprinkling of sage and parsley, tomato sauce, mushroom ketsup, chutney, or pickle sauce. You need a moist, even mixture without lumps.

Line plates or flat tins with thin short crust, or with hot-water pie paste, and put in a good filling of your mixture. Moisten the edges, cover with pastry, flute the patty rim or close and decorate with a fork pressure, make two slits in the top, brush with milk, and bake in a moderate to warm oven for 30 to 45 minutes, longer if raw meat is used. Serve cold in warm weather, with lettuce leaves, or cress, warm up and serve hot in cold weather.

Canadian Nutrition Problems

(*Concluded from page* 42)

products. The use of our own foods should be encouraged. The war has restricted exportation of a number of Canadian foods and farmers have suffered as a result. Moreover, it is advisable for us to curtail the use of foreign exchange, especially for non-essentials. A good slogan at the present time would be: "Keep Canadians fit by the proper use of Canadian foods."

In time of war it is particularly important that our people be as well fed as possible to maintain health and working efficiency on as high a level as is attainable. The status of nutrition is not satisfactory and could be markedly improved with little expense by an intensive programme of education.

Index to Advertisers

JUNE, 1941